R.N.

a journal for nurses

November 1953

Your hands need the extra protection of PACQUINS HAND CREAM

...made especially for you!

Pacquins Hand Cream for extra-dry skin is lanolin-rich. Pacquins gives more hands protection than any other hand cream in the world. Never sticky or greasy; vanishes quickly.

Pacquins was originally formulated for professional use only.

On sale at all drug counters in U. S. and Canada

R.N.

R.N. Nov. 1953; Vol. 16, No. 14. Published monthly by The Nightingale Press, Inc., 210 Orchard St., East Rutherford, N.J. Subscription $1 a year, 25c a copy; Canada and foreign countries $3 a year. Entered as second class matter. Nov. 20, 1951, at the post office at Rutherford, N.J., under the act of March 3, 1879.

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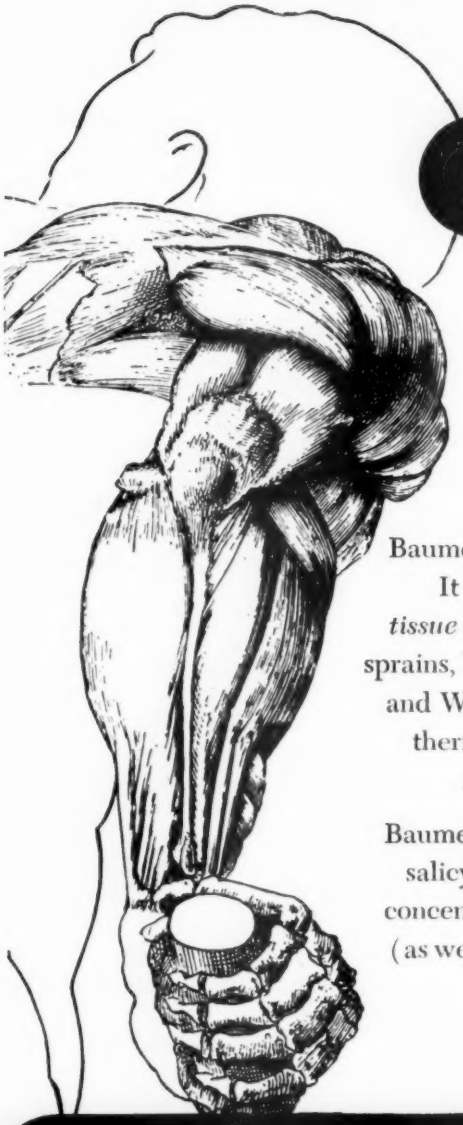


going deep

The "hyperkinemic" activity of Baume Bengué goes beneficially deep. It enhances blood flow *through the tissue area* in arthritis, myositis, muscle sprains, bursitis and arthralgia. As Lange and Weiner[1] determined by the use of thermo-needles, hyperkinemic effect may extend to a depth of 2.5 cm.

Baume Bengué also promotes systemic salicylate action. It provides the high concentration of 19.7% methyl salicylate (as well as 14.4% menthol) in a specially prepared lanolin base to foster percutaneous absorption.

Baume Bengué

ANALGESIQUE

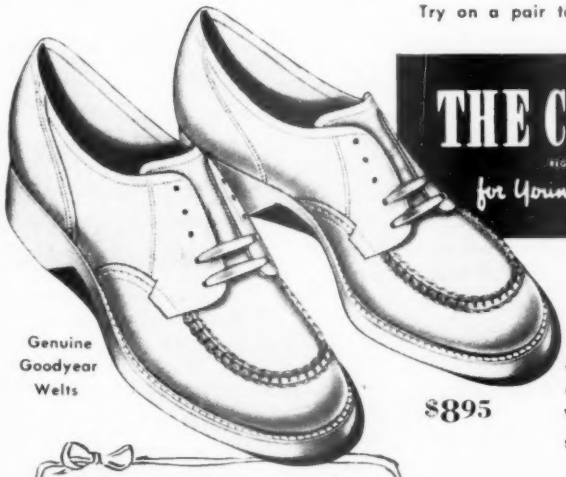
1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

Available in both* regular *and* mild *strengths.

Thos. Leeming & Co. Inc. 155 E. 44th St., New York 17, N.Y.

YOU can make life easier for **ME?**

Absolutely, darling! Clinics will speed you...
spring you...breeze you...through the day!
Clinics are softer...smarter...stronger!
Try on a pair today.



Genuine Goodyear Welts

THE CLINIC SHOE

REG. U.S. PAT. OFF. AND CANADA

for Young Women in White

$8.95

$7.95 to $9.95

(everywhere, in the U.S.A.)

Style #411, Soft Glovelk, unlined for flexibility. White duflex nap or leather sole.

FOR YOU...a complimentary pair of white shoe laces and the new Clinic folder showing all styles made. Send name and address to:

Clinics available in sizes to 12—AAAA to E
(No extra cost for large sizes)

THE CLINIC SHOEMAKERS, 1221 LOCUST ST., DEPT. RN-11, ST. LOUIS 3, MO.

A body rub that
CONTAINS THE INGREDIENTS
to Relieve Bed-chafed Skin EFFECTIVELY

EVER SINCE doctors and nurses discovered eighteen years ago that Dermassage was consistently helping to prevent bed sores and keep patients comfortable, lotion type body rubs that "looked like" Dermassage have come out in growing numbers.

But how many products *for patient use* would you choose by their appearance?

Dermassage helps you to keep the patient comfortable and free from bed sores *because it contains the ingredients to do the job.*

It contains, for instance: LANOLIN and OLIVE OIL—*enough* to soothe and soften dry, sheet-burned skin; MENTOL—*enough* of the genuine Chinese Crystals to ease ordinary itching and irritation and leave a cooling residue; germicidal HEXACHLOROPHENE—*enough* to minimize the risk of initial infection, give added protection where skin breaks occur despite *precautions;* plus additional aids to therapy. With such a formula and a widespread reputation for silencing complaints of bed-tired backs, sore knees and elbows, Dermassage continues to justify the confidence of its many friends in hospitals.

LABORATORY REPORTS—offer explicit data on the positive protection afforded by Dermassage.

FOR YOUR PERSONAL ENJOYMENT

4 Good Grooming Aids! Full sized packages of our four favorite products—YOURS for $1.00 to cover only our packing and mailing costs:

DERMASSAGE—Antiseptic body rub.

DERMACLEANSER—Soapless shampoo and bath deluxe.

ALLEGRO—Lotion deodorant—better for you!

TRI-BASIC—Improved professional tooth powder.

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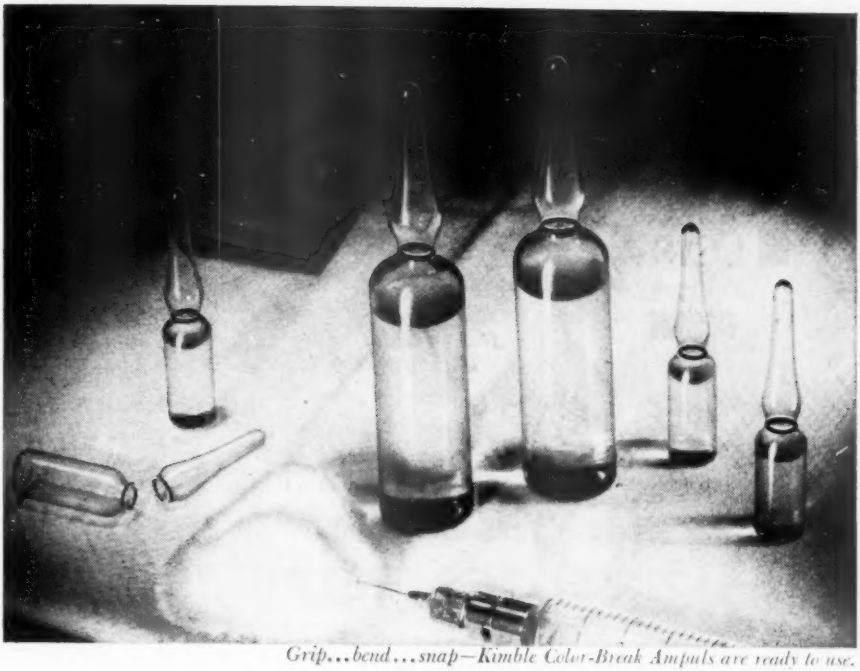
30 WEST WASHINGTON, CHICAGO 2
Please send me the 4 Good Grooming Aids described. I enclose $1.00 to cover packaging and mailing.

NAME_____

ADDRESS_____



Grip...bend...snap—Kimble Color-Break Ampuls are ready to use.

Of special interest to the medical and nursing professions

Soon you will receive from your pharmaceutical supplier parenteral solutions in a completely new kind of ampul

You will need no file for cutting the ampuls . . . for the ampuls will be the new Kimble Color-Break* Ampuls that never need notching or nicking to break easily and cleanly.

Just pick up a Kimble Color-Break Ampul as you would an ordinary ampul.

Hold it in the ordinary way.
Press on the top as you always have with ampuls.

Snap! And Color-Break Ampuls are ready for use.
No filing. No scoring. No sawing.

Kimble Color-Break Ampuls are coming off the filling lines of many producers of parenteral solutions. And, remember Color-Break Ampuls are Neutraglas ampuls. When you get a carton of them, remember: with patented Color-Break Ampuls, just snap off the top. *There is no filing, no scoring, no sawing.*

KIMBLE GLASS COMPANY

Toledo 1, Ohio—*Subsidiary of Owens-Illinois Glass Company*

*Color-Break is a trade mark of the Kimble Glass Company

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DOES HELP!

How often have you seen sickness fade and eyes brighten, when flowers arrive in a patient's room?

That's what we call *Floral Therapy:* the warmth and beauty and "cheer-up-brightness" that flowers bring . . . not only to a sick*room*, but to a sick *person*.

And your F.T.D. Florist delivers fresh flowers . . . pre-arranged for your convenience. They need no special care.

No extra work or handling with F.T.D. FLOWERS!

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FLORISTS' TELEGRAPH DELIVERY
Send Flowers Worldwide
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the best – less than $1 a pair

The same top quality, pure white, stain resistant
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that your department store sells for more
than twice the price.

MURNOCA WHITE NYLONS are the choice of
nurses in leading hospitals everywhere.
Actual test-wear has proved that
MURNOCA meets the high and
exact standards of the
nursing profession.

AVAILABLE IN SHORT, MEDIUM OR LONG LENGTHS

A *Dependable, Convenient,* and *Economical*
source for your white nylons — a company with
15 years' experience in the mail order business!
Large volume and direct selling by mail keep
our costs and prices low.

long service — style correctness

SEND YOUR TRIAL ORDER TODAY—MONEY GLADLY REFUNDED IF YOU'RE NOT PLEASED
ALL ORDERS SHIPPED PREPAID AND INSURED BY RETURN MAIL

COOPERATIVE BUYING SERVICE, DEPT. M-6, BOX 24, MURPHY, N. C.
(Reference: Citizens Bank & Trust Co., Murphy, N. C.)

Please send me_____ boxes of white nylons as checked below. Enclosed is check or money order for $_____

NAME_____

STREET_____ CITY_____

MINIMUM ORDER – ONE BOX OF THREE PAIRS, SAME STYLE AND SIZE

STYLE	DESCRIPTION	PRICE	QUANTITY	FOOT SIZE	LENGTHS S — M — L	AMO
601	60 gauge, 15 denier. White DuPont Nylon in a delicate sheerness that lends a subtle touch of flattery to your legs, yet professionally correct.	3 pairs per box, $2.90 (Less than 97c per pair)				
510	51 gauge, 15 denier, White DuPont Nylon in a very popular medium gauge offering the ultimate in both appearance and serviceability.	3 pairs per box, $2.55 (only 85c per pair)				
400	Seamless Mesh, 15 denier, White DuPont Nylon, run resistant sheerness with exceptional wearing qualities.	3 pairs per box, $2.45 (Less than 82c per pair)				
345	45 gauge, 30 denier, White DuPont Nylon in a slightly extra weight for added wear and whiteness; for the more conservative taste.	3 pairs per box, $2.55 (only 85c per pair)				

EXTENSIVE CLINICAL TESTS BY DOCTORS PROVE

Clearasil Medication

EFFECTIVE FOR PIMPLES

(9 out of 10 cases cleared up or definitely improved)

SKIN-COLORED . . . *hides pimples while it works*

CLEARASIL is the new scientific medication developed *especially* for the treatment of pimples. Doctors and skin specialists have proved its effectiveness in controlled clinical tests. In these tests on 202 patients, 9 out of every 10 cases were cleared up or definitely improved.*

And in day-by-day use thousands of nurses, too, have experienced and observed the amazing effectiveness of this new medication.

CLEARASIL combines sulphur and resorcinol in a revolutionary greaseless and quick-drying base that works to dry up pimples. *Antiseptic*, stops growth of bacteria that can cause and spread pimples. Skin-colored . . . hides pimples while it works . . . ends embarrassment. Pleasant to use. Won't stain clothing or other fabrics.

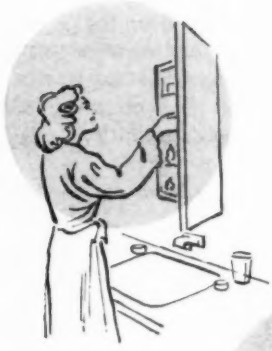
Each package contains an authoritative, helpful leaflet on general skin hygiene and living habits. You can recommend CLEARASIL with confidence. 59¢ and 98¢ at all druggists, with money-back guarantee of satisfaction.

For FREE PROFESSIONAL SAMPLE and copy of clinical report, write Eastco, Inc., Box 12RNF, White Plains, N. Y.

*Original clinical reports in our files

Relief from Recurrent Pain

Patients will appreciate the speed with which Anacin provides relief from pain and discomfort of functional dysmenorrhea and other types of simple recurrent pain. This dependable APC formula *is* fast-acting and the analgesic effect continues over prolonged periods of time. Anacin provides mild sedation, is pleasant to take—patient tolerance is excellent. Consider Anacin for *your* patients.



WHITEHALL PHARMACAL COMPANY
22 East 40th Street, New York 16, N. Y.

ANACIN

Debits and Credits

Help Wanted

Dear Editor:

The Navy Nurse Corps is interested in obtaining uniform insignia worn by members during the years 1908 to 1930. These will be used in a display showing the insignia from the establishment of the Corps to the present day. Photographs will also be appreciated. With the owner's permission these photographs will be copied and the original returned if the owner desires. Any articles or pictures may be sent to Captain Winnie Gibson (NC) USN, Director, Nurse Corps, Bureau of Medicine and Surgery, Navy Department, Washington 25, D.C.

WINNIE GIBSON
CAPTAIN (NC) USN
WASHINGTON, D.C.

Why Membership Drops

Dear Editor:

Your September editorial [*Nurses Are Joiners*] was a very practical and necessary one. I'd like to list some more reasons why nurses are not joining their professional associations:

Recently, a young nurse who is moving around the country with her soldier husband apologized for not belonging to our Official Bureau. "I was not registered in this state when I came here. I tried to register with the Official Bureau and was told they were not interested until I had my reciprocity . . . I needed to work, so I went to a commercial bureau and they took me in. By the time my reciprocity did come through, the commercial bureau had supplied me with the work I needed, and had been so gracious to me that I didn't have the heart to leave them. I felt, in fact, that I owed it to them to stand by them since they had stood by me."

Another thing that keeps nurses out, or makes them leave, is a sense of unfairness. A district I know of sends its ballots for new officers out in November, with a December deadline. In order to vote, a nurse must pay her next year's dues. In short, if you don't pay your dues at least a month before they are due, you can't have a voice in selecting your district officers. The payment, just a month before Christmas (which is also the time the last half of the year's Bureau dues are due) comes at the worst possible time. Yet organization wonders why more nurses are not interested in voting!

Another deterrent to membership is the problem of transferring from one state to another. I know of one private duty nurse, for example, who

resigned by mail, sending the letter to her Bureau chairman. Thinking that one letter would take care of her resignation, she did not send another one to her District secretary. When she returned to the state, she asked for a transfer back to its association, and was told she would have to pay a fine of $5 because she did not resign properly when she left. She paid the fine, and was then allowed to pay her Bureau dues. Then she was informed that the Bureau could not place her on duty until the Bureau Committee held its next meeting and voted her in. If such a girl is loyal to organization, she will wait for these technicalities to be accomplished. If she isn't, or if she needs work immediately, she will go to a commercial bureau. And "organization" will have lost her from its fold forever.

Bureau officials do not make these rules—they merely execute policies established by the nursing body. But can't such rules be changed when they are nooses around the neck of organization as well as the individual nurse?

R.N., SAN ANTONIO, TEX.

Small But Mighty

Dear Editor:

Please send me about a dozen applications for subscription to **R.N.** We have a local nurses' club that meets once a month, and I know some of the nurses who do not receive it already would like to subscribe to your magazine. Our club has about thirty members and we

are active in national defense, being trained by a doctor who is also training dentists in this work. At our local meetings, we have lectures on various subjects given to us by doctors. We have given $100 in scholarship aid to high school graduates, purchased a weight and height scale for one of our new schools, and we have a Lending Cupboard to which townspeople contribute items like bedpans and crutches.

(MRS.) SOPHIA E. EVANGER, R.N.
LOMBARD, ILL.

[*What sections or districts within organized nursing have demonstrated this kind of community spirit? Nursing clubs appear to be the hope for nursing—unless there is a re-alignment of programs in our official nursing associations soon.*—THE EDITORS.]

Those Dratted Gremlins!

Dear Editor:

In the letter from me [Earning Our Way] which was printed in the August **R.N.**, the statement about R.N.'s who work a six-day week and receive seventy-five cents an hour should be applied to *general* duty nurses, not private duty.

(MRS.) MARGARET M. JOHNSON, R.N.
MALDEN, MO.

Take to TV?

Dear Editor:

Your July editorial [*How Thoughtless?*] hit a responsive chord and I would like to express a few of my own opinions about how unthinking we are when it comes to thinking

NEWS ABOUT A BAUER & BLACK PRODUCT

Now—even your mirror can't tell you have varicose veins

New NYLON elastic stockings from Bauer & Black

Confidentially yours—because no one has to know you wear them. Bauer & Black *Nylon* Elastic Stockings are *truly* inconspicuous. *Wear them on or off duty*—no telltale look even under white uniform hosiery. The first elastic stockings that won't discolor—in a new, light, fashionable shade.

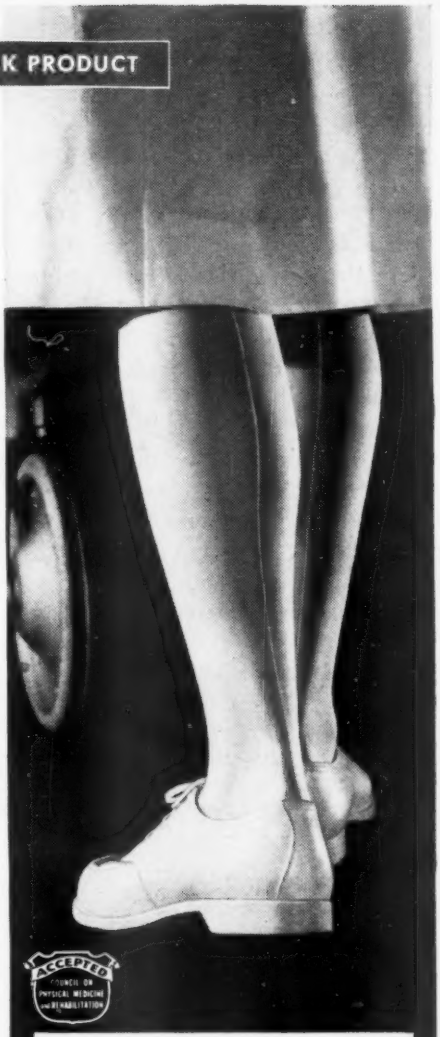
Therapeutically correct—because they're *fashioned* in 2-way-stretch elastic that exerts correct pressure from top to bottom. The kind of support 3 out of 4 doctors specifically prescribe for surface varicose veins.

Open toe for foot comfort. Cool. Light. Long-wearing. Fast drying. Reasonably priced.

BAUER & BLACK

ELASTIC STOCKINGS

Division of The Kendall Company



Send TODAY for FREE booklet on varicose veins

Bauer & Black, Dept. RN-11
309 W. Jackson Blvd., Chicago 6, Ill.

Please send___booklets with latest information on varicose veins.

Name_____

Address_____

City_____ Zone___ State____

seriously about our professional problems.

Young nurses marry so rapidly after leaving training that they represent only a small per cent of the profession today. Yet these young people are the ones we should concentrate upon reaching and stimulating. It seems to me we might reach them and the general public simultaneously by setting up some sort of educational television program. I spoke of such a program for nursing schools and was told that there was not enough public interest to warrant such a show on TV.

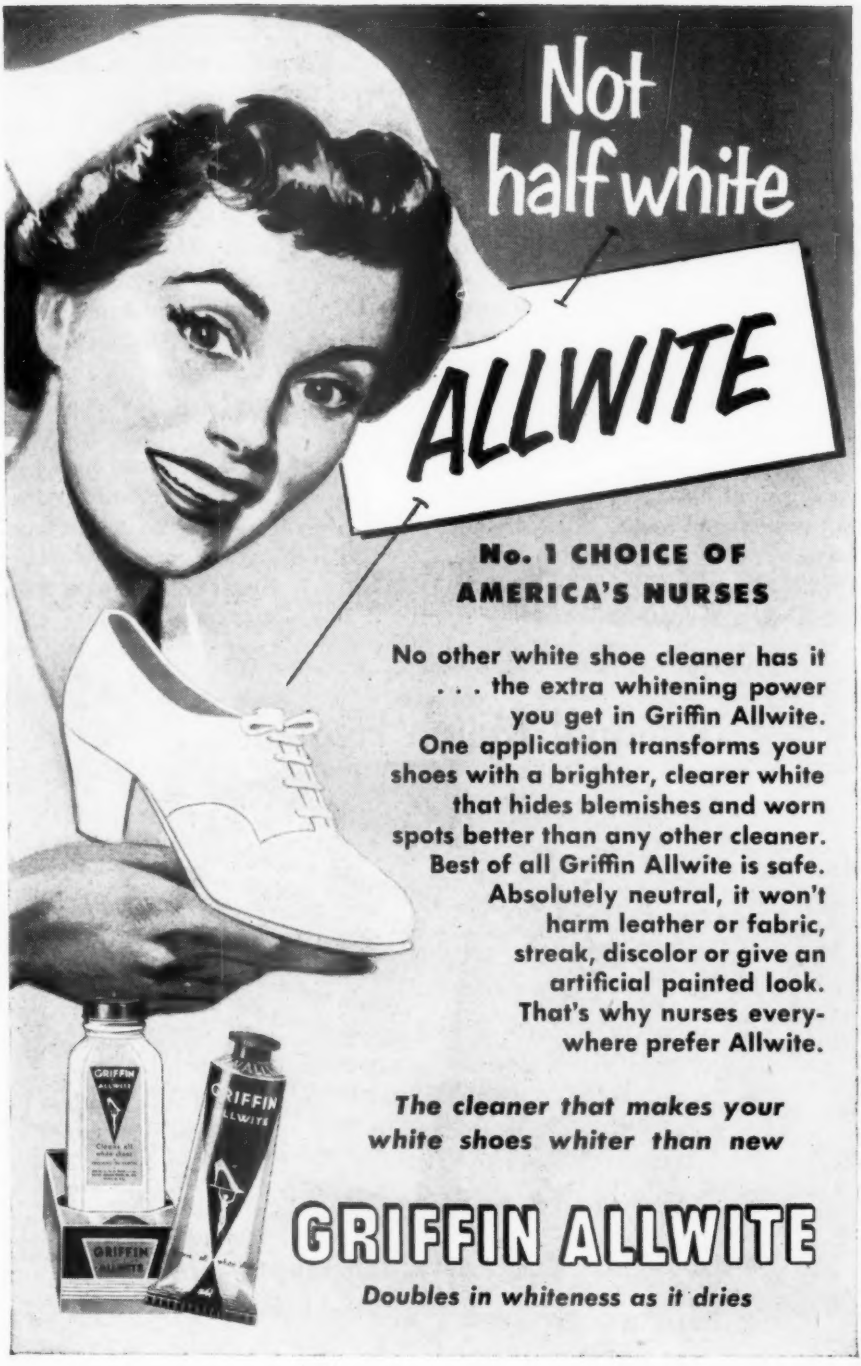
Isn't the public just as interested in nursing as in public schools? Isn't the health of a community as important as its education? (I ask these questions because apparently there is sufficient public interest in education to justify all sorts of panel discussion programs.)

I believe that we are overlooking a very effective method of promoting a better understanding of our profession in the public mind.

S. LEE ABBETT, R.N.
COVINGTON, KY.

[You must have been reading our minds. "Who's Telling Nursing's Story to the Community?" was a scheduled subject for a future editorial. In gathering data for its preparation, figures in the printed ANA budget are revealing. The budget for the year for various public relations enterprises is approximately $55,000 of which $150 is earmarked "Radio, Press, etc."

It would seem that such excellent


Not half white
ALLWITE
No. 1 CHOICE OF AMERICA'S NURSES
No other white shoe cleaner has it . . . the extra whitening power you get in Griffin Allwite. One application transforms your shoes with a brighter, clearer white that hides blemishes and worn spots better than any other cleaner. Best of all Griffin Allwite is safe. Absolutely neutral, it won't harm leather or fabric, streak, discolor or give an artificial painted look. That's why nurses everywhere prefer Allwite.
The cleaner that makes your white shoes whiter than new
GRIFFIN ALLWITE
Doubles in whiteness as it dries
GRIFFIN
ALLWITE

channels of communication as "Radio, Press, etc.," would warrant more budgetary interest than it obviously does. We repeat: Who is telling nursing's story to the community?—THE EDITORS]

It Takes Time

Dear Editor:

In reading **R.N.** I frequently come across articles that hit close to home. After a housekeeping and child-bearing vacation, I am again getting back into the swing of things in nursing. Short part-time tours of duty in various hospitals have left me astounded by the changed status of aides and practical nurses. A good aide has always been a jewel on a busy floor, and always reverently appreciated, but the years seem to have upset the equilibrium of status. I have had the unique experience of an aide (a woman having the "confidence" of several years on the floor) being contemptuous of my trained caution in double-checking unfamiliar medications.

Fools rush in! The value of extensive and concentrated training, the value of disciplined intelligence, can never be obtained through a cursory course in procedure or from on-the-job training. The skill and consideration with which a nurse may carry out a procedure can never be compared with the well-meant performance of an aide, no matter how menial the task performed may be.

(MRS.) ROSALIND FARBER, R.N.
PARAMUS, N.J.

Of exquisite delicacy...

Dandelion Puff

The infant's skin is also a structure of exquisite delicacy.

This is why Johnson's Baby Lotion is so carefully formulated... why it has been subjected to the most exhaustive research studies in both the laboratory and the clinic.

These studies have shown that in the prophylaxis and management of the common dermatoses of infancy, Johnson's Baby Lotion is a highly effective agent... as well as an ideal lotion-type product for routine baby skin care.

Johnson's Baby Lotion

Why force a child to take a laxative?

Children Enjoy Taking Fletcher's CASTORIA
The Laxative Made Especially For Them

Yes, you can administer and recommend Fletcher's Castoria for children of all ages with complete confidence. For this gentle, natural vegetable laxative won't upset sensitive little stomachs. Yet it works thoroughly . . . and you can control the dosage exactly.

And it tastes so good, there's never any coaxing or fussing. Children take it readily.

Chas. H. Fletcher

The Original and Genuine

CASTORIA

Especially Made for Infants and Children of All Ages

CLASSIC BEAUTY...

Modern Style

the uniform is by

Dix-Make

Two manufacturers with one primary objective — "TO GIVE THE AMERICAN NURSE THE FINEST PRODUCT IN THE WORLD!"

the shoe is by

Haymakers®

The uniform is Dix-Make's style 273. Made of beautiful sanforized poplin. Featuring attractive step-tucking on the blouse, a convertible collar and deep slash pockets. This ¾ sleeve uniform is available in sizes 10 to 20 and in junior sizes 9 to 15. Reasonably priced at only $9.00.

The shoe is Haymaker's hand-made Wedge-Tie. Made of 'butter soft' kip-calfskin in colors white, red, benedictine, black, navy and brown. Sizes: AAAA 5-11, AAA 4½-11, AA 4-11, A, B, C, 3½-11. Reasonably priced at only $14.95. In Wedge-Tie (as shown), Oxford (with outside heel) and Pump.

For ordering uniforms send the coupon to Dix-Make, for shoes send the coupon to Haymaker — if you wish to order both, send coupon to either address.

Latest catalogs are available from both Dix-Make and Haymakers. Simply send your request to either address.

	STYLE	SIZE	QUANTITY	COLOR
DIX	273			WHITE
HAYMAKER	Wedge-Tie			
	Oxford			
	Pump			

Dix-Make
UNIFORMS
29 West 30th Street
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Haymakers®
THE SOFTEST SHOES THAT EVER WALKE
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works full time for you...

Bactine®

germicide
fungicide
deodorizer

on duty

- Hand disinfection
- Back rub
- Skin preparation for injection
- Syringe and needle disinfection
- Thermometer disinfection
- Deodorizing sickroom
- Antisepsis plus cleansing action

off duty

- First aid—cuts, abrasions, minor burns
- Sunburn
- Athlete's Foot
- Insect bites
- Poison ivy
- Tired aching feet
- Antiseptic mouthwash
- Personal hygiene

Bactine works overtime, too

Bactine **has a prolonged antibacterial and fungicidal action that lasts for hours. On hospital or private duty, *Bactine* is pleasant to use—it does not stain, has a clean, fresh odor, is antipruritic and soothing to skin. It contains no mercury, iodine or phenol.**

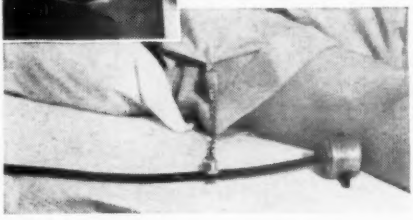
Bactine: **Available in 1-gallon, 1-pint and 6-ounce bottles from your regular supplier.**

MILES LABORATORIES, INC • ELKHART, INDIANA

New on the Market

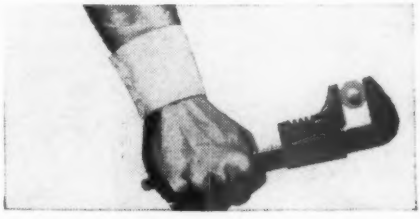
A "Scotch" brand, autoclave tape that ends need for tying or pinning bundles, and is useful for labeling trays, pans, jars, etc., is said to hold fast under steam (up to 250° F). Made by Minnesota Mining and Manufacturing Co., No. 216 tape is sold by hospital supply houses.▶

◀A non-tearing fastener, called Peck's Hospital Signal Cord Holder, keeps I.V. tubes, catheters, and movable objects in place. Single holders (35¢ ea.) and double ones (50¢ ea.) may be obtained from nurse-inventor, Mrs. Florence L. Peck, 504 West First St., Ulrichsville, Ohio.



Dorset Diet soups and meat items, sold at diet shops and chain stores, make dieting easy. Labels list protein, carbohydrate, etc., also caloric and sodium content of each individual can.

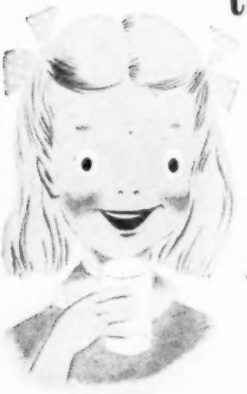
An A.C. Flash Lite Pen, with non-smudge ballpoint replaceable ink cartridge, lights the way for night nurses needing to write in darkness or semi-darkness. Priced at $1.95 plus 5¢ for delivery, this compact pen is supplied by Aaron Cohen, 130 West 42 St., New York, N.Y.▶



◀Bauer & Black's new "one-size" Elastic Wristlet features comfort as well as wrist support for all wrist sizes—6 to 8 inches. By adjusting the first turn of this easy-to-launder, flesh-colored wristlet and fastening snaps, webbing stretches to apply the correct pressure.

Children take it without the least bit of fuss...

SWALLOWED WHOLE



CHEWED— OR IN FOOD OR LIQUID

DISSOLVED ON TONGUE

- The Best Tasting Aspirin You Can Recommend.
- The Flavor Remains Stable Down to the Last Tablet in the Bottle.
- 24 Tablet Bottle . . . 2½ gr. each 15¢

2½ gr. ◐ ⇨ ◑ 1¼ gr.

Grooved Tablets— Easily Halved.

NEW FLAVORED

CHILDREN'S SIZE

BAYER ASPIRIN

We will be pleased to send samples on request

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SOMETHING NEW . . .

Single-Use unit of 4½ oz. contains in each 100 cc., 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate—an Enema Solution of PHOSPHO-SODA *(Fleet).*

The

FLEET ENEMA

Now in the new single-use disposable unit

A distinctive feature of this unit is its sanitary rectal tube protected by the cellophane ***envelope. After the tube is in position, the enema solution is instilled by squeezing the*** polyethylene ***container. A*** special rubber ***diaphragm prevents leakage and provides controlled rate of flow.***

SEGMENTAL CATHARSIS with the Fleet Enema affords clinically proved[1, 2, 3, 4, 5] advantages for proctoscopy and sigmoidoscopy[4]—for preoperative cleansing and postoperative use[2, 5]—to relieve fecal or barium impactions[1, 2]—for use in collecting stool specimens[3]—as a routine enema. Extensive experience shows that "*within two to five minutes* the left half of the bowel empties completely *without pain or spasm.*"[2]

1. Burnikel, R. H. & Sprecher, H. C.: Am. J. Dig. Dis. 19:191, 1952.
2. Marks, M. M.: Am. J. Dig. Dis. 18:219, 1951.
3. Marks, M. M.: Personal communication, 1952-1953.
4. Sweatman, C. A.: J. South Carolina M. A. 49:38, 1953.
5. Hamilton, H., in Trans. 5th Am. Cong. Obst. & Gyn., Mosby, 1952, p. 69.

there is only one

FLEET ENEMA

DOSAGE: Adults: 4 ounces. Infants and children: 2 ounces or as directed by physician.

'Phospho-Soda' and 'Fleet' are registered trademarks of C. B. Fleet Co., Inc.

Available through your regular source of supply.

C. B. FLEET COMPANY, INC.
Lynchburg, Va.

No alarmist, I

■ "UNSUPERVISED WORK is demoralizing," wrote nursing's Mary Gardiner, and her words were prophetic. What has been happening in our hospitals since World War II is prima facie evidence that here is one of nursing's most vulnerable spots in the care of the patient.

Hospital nursing staffs have multiplied by hundreds of percents, and thousands of supervisory and head nurse positions have been created. During this expansion, we have been made acutely aware that we haven't the supply of *qualified, adequately prepared* supervisors, instructors, and administrators to meet the unforeseen demands, yet we know that sound supervision is the very backbone of all good nursing.

At present we not only have a paucity of quantity from which to draw upon for administrative positions, but we are fighting a constant battle to keep from diluting the quality of those within the ranks. At a time when we must prepare more, we have less to work with. It is because of these unprecedented pressures that we desperately need more skilled leadership than ever before.

Today's administrators must not only have a sound educational and technical background, but they must be constantly alerted against separating themselves from the reality of their work. No amount of training is a substitute for knowing what is going on within one's own organization. An administrator must know what he or she is administering. "Miss ——— would never permit this if she knew what was happening," the staff nurse told me when I questioned her about a situation on a hospital floor. Earlier I had talked with Miss ——— and heard her rationalize a satisfactory excuse to herself for not making regular hospital rounds—the other demands on her time were too numerous—the community, her board of trustees, etc. Busy administrators must have a sense of values. However, it is an individual matter how these values are weighed. Miss ———'s services were dispensed with about one year after that incident. It could just possibly be that too many things *happened* in the hospital of which she wasn't aware.

When supervisors or administrators do their own observing and

interpretmg, rather than using the eyes and minds of others, there is less likelihood of their losing their understanding of the real problems attending patient care. How subject to criticism are those who climb the success ladder only to join that portion of nursing's hierarchy so removed from direct contact with patient care that they in their ignorance of what's going on initiate much of nursing's headaches and heartaches—and, to put it more strongly—are in several ways directly responsible for the poor patient care and the sick morale in nursing today.

Recently a French priest told a group of professional people of a trend in his order to keep the priests with the people they lead spiritually. He recounted the story of the young novice who, after several years of study for the priesthood, failed in health and had to give up his preparation and return to his former position. A remark by one of his shopmates, who asked him: "Why do you come back?" and, more significant, "Your book learning has already separated you from the rest of us," started this trend to bring priests back to work beside their people at their jobs, attending to official pastoral functions after work hours.

We like this idea even though *Time* [Sept. 28] reports calamity in this particular movement. Communist French workers appear to be having as much or more influence on the French worker priests as do the priests on the workers. However, despite the unfortunate transmission of communist ideologies, it does demonstrate the filterability of ideas when one is closely associated with them. As the pressures continue for nursing to fill the unprecedented need for administrators, the danger of a widening gap between bedside nursing and administrators of nursing increases. Experience in human relations has shown that distances grow greater as size and specialization increase. Nursing's first reponsibility *is to the patient*—let us keep this idea constantly before those few nursing leaders who have strayed too far from the workbench. Advancing nursing's professional status, and achieving academic recognition is certainly important, but not at the expense of patients.

—Alice R. Clarke, R.N

The Rehabilitation of Greek Nursing

ITHACA
CEPHALONIA

ZAKYNTHOS

■ AT THE END of World War II, public health organization in Greece was, quite simply, non-existent. War and enemy occupation had completely destroyed the pre-war facilities for dealing with health problems. Greeks near death from various maladies paid enormous black market prices to the Nazis for medicines, which in some parts of the country were choking warehouses. In other cases, not one gram of many basic drugs could be found. Hospitals had been looted or destroyed, while medical schools were in an equally pathetic condition, lacking such essentials as equipment, staff, and students.

When Greece was finally liberated in 1944, a tide of sympathy swept across the U.S. as the full facts of the Greek tragedy became known. That emotional response found outlet in many ways. There was general public acceptance and support of UNRRA relief work, with the U.S. assuming more than 70 per cent of the costs. There was increased backing for such long-established agencies as the YMCA and the YWCA. And there was Greek War Relief.

A large part of the money collected went for food and clothing to keep Greeks alive. But most of it went into public health. In the postwar years, American aid and advice have played a major part in restoring the Greek health service and in bringing new hope to a people in dire need. That achievement makes an inspiring story of the triumph of human endeavor over almost insurmountable difficulties.

When confronted at war's end with the bleak situation, the staff members of the public health division in the American Mission commented that at least they were starting with a clean slate. They scoured the nation to find Greek colleagues who could help them to alleviate a situation which everyone admitted was virtually hopeless. They found many devoted men and women who, despite surface pessimism, worked night and day to restore Greek pub-

lic health services for the people.

The public health activities of American aid have eventually affected almost every phase of Greek life. The major divisions embraced hospital construction, sanitary engineering, public health nursing, tuberculosis control, training of medical personnel, health education among the people, and an extensive program of preventive medicine. The funds for so vast a re-organization came only partly from the private American help to Greece, substantial and important though that help has been. The basic job has been accomplished under the Marshall Plan, with funds administered jointly by the American Mission and the Greek Government, according to principles evolved during two centuries of U.S. public health activities.

A major problem has been the acute shortage of graduate nurses. When American aid began, the need for nurse training was dictated by the realities of the civil war which raged for several years and hampered all recovery efforts. Accordingly, first priority went to in-service training of practical nurses already serving in hospitals. When that program was completed in 1950, a total of 1,293 practical nurses and seventy-four hospital corpsmen had attended training courses of six to eight weeks in forty-five institutions.

Second in priority—but probably more important in long-range terms—has been the training of graduate nurses, who in every nation form the professional core of public health work. This training has progressed rapidly, assisted by more than $10,000 worth of special teaching aids imported for three nursing schools in Athens and Salonika.

In Athens, a new addition to the nursing school and home was dedicated at the Greek Red Cross hospital in November of 1951. This building is one of the most modern in Europe, providing facilities for fifty additional students. Similarly, a new nursing school and home was built with American assistance at Salonika where the first nursing class was enrolled early last year. A standard curriculum of studies was approved by the Nursing Council and is now followed by all schools of professional nursing.

Presently, five nursing schools are in operation in Greece. Four of these offer three-year courses, and the fifth, the Soteria Sanatorium, has a one-year course. An average of ninety to one hundred trained nurses are graduated annually from the three-year schools and thirty-five to forty nurses are graduated from the one-year school. At the end of 1950, the total number of trained nurses who had completed one year of training was 192; 1,130 had completed three years of study. The group of active nurses consisted of 820 three-year nurses and 120 one-year nurses. It should be noted, too, that voluntary nursing sisters, numbering 5,500, rendered invaluable services in caring for the sick.

A third major category is that of public health nursing. The entire emphasis of the Greek public health program is now swinging more and

more toward the improvement of facilities in the rural areas of Greece which traditionally have lacked medical attention. The key figure in that program is the public health nurse who makes her rounds among the country people, teaching hygienic practices, treating routine ailments, inoculating children against common diseases, and referring serious cases to appropriate doctors.

Several months ago, the eleven Greek War Relief health centers in rural Greece finally reached their full complement of public health nurses. In addition, 300 public health nursing bags, purchased through American aid, have been distributed. A public health nursing supervisor, who had completed a year of postgraduate training in the U.S. under a technical assistance program, was added to the nursing staff of the Directorate of Hygiene.

Altogether, in the whole sphere of nursing, American specialists have worked closely with the nursing section of the Greek Directorate of Hygiene. With American urging, a Nurse Practice Act was adopted by the Greek Parliament in 1950, and the Hellenic Nurses' Association was revived the same year. Both actions have helped stabilize the nursing profession, enhance its prestige, and increase its usefulness to the nation.

Recognition of American help was marked in 1951 by the award of the Certificate of Merit with Silver Medal of the Greek Red Cross to Margaret E. Willhoit, formerly chief nurse in the public health nursing section of the Marshall Plan's Mission to Greece. Throughout 1948, during the height of the Greek civil war, Miss Willhoit worked in close association with the Greek Red Cross, spending most of her time in the field assisting in health problems among refugees. Later she directed the Marshall Plan program of selecting Greek doctors, nurses, and medical engineers who were sent to the U.S. and Western Europe for postgraduate studies.

That program of postgraduate study forms an essential link in the task of raising Greek medical facilities to Western standards. During 1951, out of a total of twenty Greek health specialists brought to the U.S., five were graduate nurses who had come for a year's work in nursing education and public health nursing. On their return to Greece, they planned to help in the spread of modern methods through the Greek health service.

Along with the shortage of graduate nurses, now fast being overcome, there was also a scarcity of the "middle layer" of public health workers—especially laboratory and x-ray technicians. Until recently, Greek doctors had to waste valuable time making routine blood and urine tests, and were unable to devote enough attention to experimental laboratory work. Therefore, the early part of last year, the American Mission agreed to give financial aid to a Greek government program to train forty-two laboratory technicians. The aim is to teach routine work in laboratory analysis to men and women who will act as assistants to doctors

skilled in microbiology. That is just one more instance of the way American aid and advice is helping to give the Greek nation an up-to-date medical service.

Since 1951, American aid to Greece has undergone a radical change. The Mutual Security Agency —successor to the Marshall Plan—is designed to channel aid funds into projects of direct defense importance only. Funds available for public health are now mostly restricted to finishing hospitals and other large construction projects which are near completion. This change marks the end of a chapter. But, fortunately, the major task of restoring Greek health services has already been completed. And the technical assistance program whereby health specialists and nurses receive postgraduate training in the U.S. will continue. That program is potentially of enormous value to Greek medicine. In addition, a campaign has begun to wipe out leprosy, venereal disease, and trachoma. The current campaign to improve health facilities in rural areas also has the benefit of advice from American specialists.

Throughout Greece today, in large cities and small towns, there are gleaming new hospitals and clinics which are permanent monuments to the sympathy of Americans for the people of Greece. Hundreds of Greeks are alive today who would have died without the care and nursing that these hospitals and clinics provide. The Greeks will not forget those who came to their assistance so readily during their darkest hour.

QUESTIONS on Health and Accident Insurance

■ ONE OF R.N.'s readers recently wrote: "I have held a health and accident policy with ——— Health and Accident Association for years. A year ago I had an acute attack of sinusitis and it was necessary for me to seek the advice and care of a nose and throat specialist. Due to the severity of the condition, it was literally impossible for me to work and I lost about two weeks' work. I submitted a claim to the company and was informed that before it would acknowledge the claim it would be necessary for me to sign a waiver or rider (the word they used) releasing it of any responsibility for acknowledging any claim in the future for sinusitis including any surgery the doctor deemed necessary. I have never submitted a claim to the company before.

"I have discussed the matter with a number of my friends who aren't in the nursing or medical profession and they tell me that this company is not very reliable."

° ° °

In the first place, the company the author refers to is the world's largest mutual benefit health and accident company and it is thoroughly reliable. It pays all legitimate claims promptly.

The matter of signing a rider to release the company from future insurance claims [*Continued on page* 68]

A MODERN GREEK TRAGEDY

For a decade, the people of Greece have suffered from man-made disaster—war, occupation, and Communist aggression. This summer, unfathomable nature dealt the cruelest blow of all, unleashing her fury upon the historic Greek islands of Ithaca, Cephalonia, and Zakynthos. The cataclysmic earthquakes that levelled 90 per cent of the towns and villages of the three Ionian islands, exacting a toll of nearly 500 dead, 1,000 injured and 120,000 homeless, shocked the entire world. Immediately, countries, including the United States, rushed medical and rescue teams to the earthquake area where they worked day and night with the Greek forces in rescuing people buried in debris, recovering the bodies of the dead, and giving food, clothing, and medicines to the injured and homeless. Outstanding members of these life-saving teams were the Greek nurses, who in the manner of their sisters throughout the world, gave freely of their professional skills.

▲ *Among the first to visit the stricken islands, were Their Majesties, King Paul and Queen Frederika. Here, an old woman tells the Queen about the loss of her home.*

◀ *Many of the earthquake victims of the Ionian islands, including 900 children, were evacuated by ship and helicopter to the Greek mainland for shelter and medical care.*

King Paul talks to some of the hard-hit inhabitants of Frangata in Cephalonia. Both he and Queen Frederika helped in giving aid to the destitute and the homeless. ➤

Mrs. Papagos, wife of the Greek Prime Minister, joined the Greek Red Cross, American Red Cross, and International Red Cross workers in caring for Ionian victims. ➤

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Midst death, terror, and destruction the birth of new life brings genuine happiness — however untimely its arrival. ➤

American nurses can help by contributing to their local Red Cross chapters. Also, the Greek Orthodox churches are collection centers for packages and contributions destined for the distressed Ionian islands.

After emergency care has been given, including preventive inoculations, there looms the more difficult goal of rehabilitation. ➤

CARDIAC ARRHYTHMIAS

by Althea Powers, R.N.

■ THE UNFAILING activity of the heart as it ceaselessly pumps blood through the circulatory system is one of those everyday miracles which we often accept all too casually. Day in and day out, year after year, this small organ continues to contract and relax on an average of seventy to eighty times each minute. It takes no vacations—when the heart stops, life ends. Small wonder then that hearts often tire, that they do not always beat with smooth, efficient regularity, and that disorders in rhythm sometimes arise.

Some of these disorders may occur in an otherwise normal heart and have little practical significance; others may arise as the result of certain noncardiac conditions such as pneumonia, diphtheria, hyperthyroidism, during anesthesia, or following excessive use of tobacco or alcohol. Organic heart disease may cause arrhythmias by upsetting the "machinery" responsible for the initiation and maintenance of cardiac beat.

While studying anatomy, we learned that the heart is divided into four chambers—the two upper chambers are the auricles—the lower chambers, the ventricles. As blood fills the auricles, they contract then relax, whereupon the ventricles contract, forcing the blood out into the arteries. In the normal heart, the contractions originate in the sinus node situated high on the right side of the right auricle. The impulses arising from the sinus node are regulated in part by various nerve reflexes produced by changes in blood pressure, respiration, and blood chemistry.

Impulses from the sinus node spread in a fanlike manner out over the auricles until they reach the auriculo-ventricular (A-V) node. They are then relayed by means of the (A-V) bundle, or the bundle of His, to a system of conducting tissue which is contained within the ventricular muscle.

Actually, impulses may originate in any part of the heart muscle, but it is the sinus node which functions as the pacemaker of the heart. This is because impulses are formed more rapidly here than in any other part of the heart. If, for any reason, some part of the heart should originate impluses at a faster rate than the sinus node, that part would then take over as the pacemaker. Disorders in rhythm result from a disturbance in the normal pacemaker, in the formation of impulses, or in the conduction of impulses.

Sometimes the sinus node sets an abnormally rapid beat (tachycardia) or an abnormally slow one (bradycardia). These conditions are rarely of importance in and of themselves, although sinus tachycardia may be

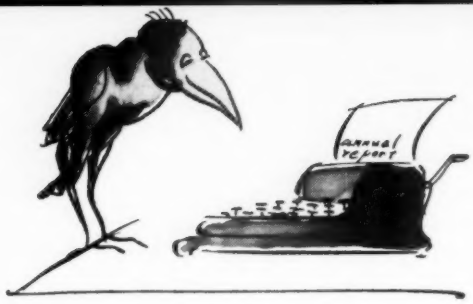
concomitant with such disturbances as anxiety states, acute infections, or shock. Patients may complain of palpitation or breathlessness, but usually, sedation, given during the period of tachycardia, is sufficient treatment. In any case, the condition tends to be self-limiting.

Occasionally, an impulse may be formed by an area of the heart muscle which is usually quiescent. Known as ectopic impulses, these impulses may become strong enough to cause premature contractions which break in upon the normal rhythm of the heart. These premature contractions are often upsetting to the patient who does not know what to make of the extra flip which his heart takes every now and then. They may occur in healthy hearts or they may accompany noncardiac or organic cardiac disease. Sometimes these premature beats are the forerunners of a more serious arrhythmia—especially if the impulses originate in the ventricle.

Not infrequently, the A-V node or the auricular muscle may give rise to impulses so rapid that they overwhelm those of the sinus node; the heart then beats in conformity with its new pacemaker at a rate which although rapid is *regular*. Usually these tachycardias are paroxysmal, and, in time, the sinus node regains its ascendancy. Pressure on the eyeballs or carotid sinus located in the neck, or the administration of ipecac or other emetics sometimes serve to relieve the tachycardia. Mecholyl, digitalis, or quinidine may be employed to terminate these arrhythmias. (*See Drug Digest*, page 42, for a discussion of these three drugs, and Pronestyl, another drug used in the treatment of various cardiac arrhythmias.)

The auricular muscle may even, under certain not very well understood conditions, behave in such an erratic manner that it actually seems to have gone berserk. There is no semblance of rhythm—only a generalized quivering and excitation of the muscle fibers. The auricles do not contract effectively. Known as auricular fibrillation, this arrhythmia occurs most commonly in rheumatic and arteriosclerotic heart disease and in hyperthyroidism which is not adequately treated. Auricular flutter is a condition much like auricular fibrillation except that the impulses occur with much more regularity.

The danger in auricular fibrillation lies in the fact that the ventricles are bombarded by an excessive number of impulses from the auricles. In response to some of these impulses, the ventricles may begin to beat very rapidly. This means that the ventricles will not have sufficient time to refill during their period of relaxation and the amount of blood pumped by the heart is thereby lessened. Since all the contractions of the ventricles are not strong enough to be transmitted to the radial pulse, the heart beat is usually more rapid than the pulse indicates. For this reason, nurses are often asked to take the apical pulse beat by means of a stethoscope so that the rate of the ventricular beats may be determined. If the ventricular



"Zeke & Dessie"

rate is not accelerated, auricular fibrillation is usually not an overly serious matter.

There are two ways of treating auricular fibrillation—either the fibrillation itself may be attacked by means of quinidine, or an attempt may be made to slow the ventricular rate through the administration of digitalis. When digitalis is given, the auricle will continue to fibrillate but the conduction of impulses from the auricle to the ventricle is slowed because of the depressor effect of digitalis on the bundle of His.

Quinidine acts directly on the auricular muscle. It limits the ability of the muscle to contract on its own initiative, and it prolongs the refractory period—that is, the period following each contraction during which the heart rests before responding to a new stimulus. There are, however, certain dangers encountered when the fibrillating auricle returns to its normal rhythm. While the auricle was fibrillating, the blood within the auricular appendages was unable to circulate very actively and it therefore afforded an environment conducive to the formation of thrombi. When the auricle contracts once again, these thrombi shoot out into the general circulation and, as emboli, may cause the death of the patient if they happen to lodge within a vital organ. Consequently, it has been suggested that one of the anticoagulant drugs be administered to patients with longstanding auricular fibrillation.

Ventricular tachycardia due to ectopic impulses originating within the ventricle itself is regarded with much more consternation than are the tachycardias arising from auricular disorders. This condition, which is often recognized only by the help of an electrocardiogram, is a not uncommon complication of acute myocardial infarction, and the added strain on the already impaired heart may actually cause the patient's death. Quinidine and Pronestyl may be given in an attempt to slow the rate of contraction. Digitalis is contra-indicated because digitalis itself, when given in large doses, may cause

ventricular tachycardia to develop.

Ventricular fibrillation is usually a terminal event. Prompt treatment is necessary if the patient is to survive, for the heart beat becomes so weak and ineffective that circulation is seriously impaired, and shock, coma, and death may ensue. Intravenous or intracardiac injections of quinidine or Pronestyl may be given as an emergency measure.

Certain disturbances of cardiac rhythm are due to a blockage in the conduction of impulses from the auricles to the ventricles. If it takes over 0.2 second for the impulse to pass from the sinus node to the A-V node, partial heart block is said to exist. This may be entirely asymptomatic, however. Sometimes only one of the two main branches of the bundle of His is affected. Known as bundle-branch block, this condition is harmless and does not require any special treatment.

When no impulse can travel from the auricle to the ventricle, complete heart block exists. When this happens, the ventricles must develop their own heart beat apart from that of the auricles. It is this beat of the ventricles which constitutes the new heart beat, although the auricles will also be contracting but at a rate and rhythm which is in no way synchronized with the ventricular beat.

Since the usual rate of impulse formation in the ventricles is slower than in other portions of the heart, the ventricle beat will undoubtedly be below 50. In cases of complete heart block, the apical or ventricular rate is considered more reliable than the radial pulse because the pulse rate is usually even slower than the ventricular rate.

Periods of unconsciousness known as Adams-Stokes episodes may occur when the ventricular rate drops to 30 or below or when short periods of ventricular fibrillation develop. In paroxysmal heart block, there may be a period of giddiness when the sinus node relinquishes its role as pacemaker and the ventricle takes over. Before the ventricle can function, it must [*Continued on page* 80]

Drug Digest

DIGITALIS U.S.P. (Cardiac Stimulant)

PRODUCT NAMES: Distributed under official name.

PHARMACOLOGY: Digitalis acts by increasing the force of systolic contraction and the auriculo-ventricular conduction time. The drug is of value in the treatment of auricular flutter and rapid auricular fibrillation because of its ability to depress conduction in the bundle of His; hence the auricular impulses are screened and only the stronger pass through to the ventricles. As a result, the contraction of the ventricles becomes more regular, both in rhythm and intensity. Digitalis is also employed in the treatment of congestive heart failure and in myocardial fibrosis.

DOSAGE: The dosage of digitalis must be suited to each individual patient. If the patient has taken digitalis within the past two weeks, this must be taken into account in determining the dosage schedule. On the first day of treatment, the average total adult dosage is about 1.5 Gm. in three 0.5 Gm. portions given at six-hour intervals; on the second day, 0.1 to 0.2 Gm. may be given two or three times daily. Dosage is regulated in accordance with the clinical response of the patient, and the average total adult maintenance dose usually consists of 0.1 to 0.2 Gm. of digitalis daily. The drug is given orally.

UNTOWARD ACTIONS: Anorexia, nausea, and vomiting may occur, due either to the irritant effect of digitalis on the gastro-intestinal tract or to the systemic effect of the drug. Other symptoms of digitalis poisoning include headache, dizziness, yellow vision, marked bradycardia, extrasystoles, coupling, auricular fibrillation, and ventricular tachycardia which may result in ventricular fibrillation and death. There is no antidote for digitalis poisoning. The only treatment is to stop the drug. On no account, is digitalis to be given in the presence of tachycardia of ventricular origin.

PROCAINE AMIDE HYDROCHLORIDE N.N.R. (Cardiac Depressant)

PRODUCT NAMES: Pronestyl Hydrochloride.

PHARMACOLOGY: Pronestyl depresses the irritability of the ventricular muscle. It is utilized in the treatment of ventricular and auricular arrhythmias and extrasystoles arising in cardiac diseases or during general anesthesia, and is believed to be more effective in ventricular arrhythmias than in auricular arrhythmias.

DOSAGE: When Pronestyl is employed in the treatment of conscious patients with ventricular tachycardia, the usual oral dose is 1 Gm. followed by 0.5 to 1.0 Gm. every four to six hours as indicated. The usual intravenous dosage is from 0.2 to 1.0 Gm. (2 to 10 cc. of a solution containing 100 mg. per cc.) administered at a speed not in excess of 1 cc. per minute. Conscious patients with auricular arrhythmias may receive a total daily oral dosage of from 1.0 to 5.0 Gms. in divided doses. An initial dose of 1.25 Gms. may be given, followed by 0.75 Gm. if no electrocardiographic changes occur. Doses of 0.5 to 1.0 Gm. may then be given every two hours until the auricular arrhythmia disappears. The usual maintenance dose is 0.5 to 1.0 Gm. every three to six hours. If runs of ventricular extrasystoles occur, 0.5 Gm. of Pronestyl may be given orally every four to six hours as indicated. To correct cardiac arrhythmias arising in the course of anesthesia, 0.1 to 0.5 Gm. of the drug may be given intravenously at a rate not to exceed 0.2 Gm. (2 cc.) per minute.

UNTOWARD ACTIONS: A hypotensive action may follow the intravenous use of Pronestyl. If the hypotension is severe, the drug is discontinued and, in some instances, a vasoconstrictor agent is administered. Leukopenia and granulocytopenia sometimes develop and the prompt withdrawal of the drug is indicated whenever symptoms of agranulocytosis, accompanied by a significant fall in the white blood count, are noted.

QUINIDINE SULFATE U.S.P. (Cardiac Depressant)

PRODUCT NAMES: Distributed under official name.

PHARMACOLOGY: Quinidine is used in the treatment of a number of cardiac arrhythmias. The main action of the drug is upon the heart muscle; in auricular fibrillation, quinidine restores normal rhythm through its ability to lengthen the refractory period and decrease the irritability and conduction time of the auricles. Because it slows the heart rate, quinidine is also of value in the treatment of paroxysmal tachycardias of auricular, ventricular, or nodal origin, and in the treatment of auricular flutter.

DOSAGE: Quinidine is usually given orally, although preparations of the drug suitable for intramuscular or intravenous administration are also available. However, the drug is given intravenously only when intramuscular administration is ineffective or when very quick action is needed. A small test dose of 0.2 Gm. is administered orally to determine sensitivity; the dosage is repeated in two hours and, if no untoward symptoms develop during the ensuing twelve hours, 0.4 Gm. of the drug may be given from three to five times daily until the heart resumes its normal rhythm. If abnormal rhythm persists after about ten days of treatment, the drug is discontinued for two weeks following which another course of quinidine is instituted. A maintenance dose of 0.2 to 0.6 Gm. may be necessary in successful cases if recurrences are to be prevented.

UNTOWARD ACTIONS: Symptoms of cinchonism such as nausea, ringing in the ears, and dizziness may develop in the presence of overdosage or idiosyncrasy to quinidine. Diarrhea, sweating, flushing, apprehension, skin rash, and urticaria may also appear. In patients with longstanding valvular disease, embolism or ventricular fibrillation sometimes occur. Quinidine is contra-indicated in bacterial endocarditis, marked cardiac hypertrophy with failure, and complete heart block.

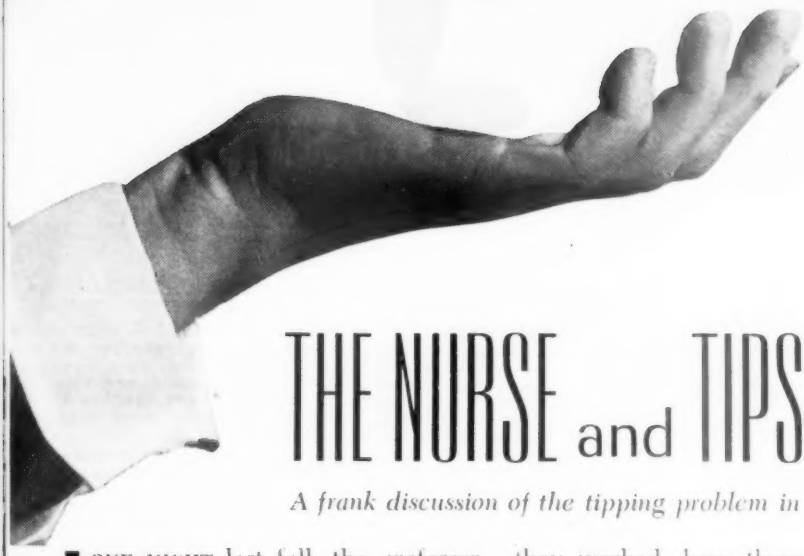
METHACHOLINE CHLORIDE U.S.P. (Parasympathomimetic Agent)

PRODUCT NAMES: Mecholyl Chloride.

PHARMACOLOGY: Because of its stimulating effect on the parasympathetic nervous system, Mecholyl may be used to terminate attacks of paroxysmal auricular tachycardia in certain selected cases when more common therapeutic measures fail. However, Mecholyl is less effective than quinidine in the prevention of these attacks. Mecholyl is also employed to increase peripheral blood circulation in the treatment of Raynaud's disease, scleroderma, chronic ulcers, and other vasospastic diseases and for the palliative treatment of chronic rheumatoid arthritis.

DOSAGE: Although Mecholyl may be given orally and locally, by the ion-transfer method, the subcutaneous route is always employed when the drug is used to terminate attacks of paroxysmal auricular tachycardia. As a rule, 10 mg. of the drug is effective in patients under 20 years of age; in patients over 20 years of age, 20 to 40 mg. may be needed. If a second dose is necessary it is well to wait ten or twenty minutes after the first dose has been given to guard against the cumulative effects of the drug. Careful, gentle massage of the site of the first injection is also recommended before a second dose of the drug is given. Injection must always be subcutaneous, never intravenous or intramuscular.

UNTOWARD ACTIONS: Idiosyncrasy to Mecholyl may cause difficult breathing. If this occurs, treatment is discontinued and the patient is placed in a sitting position. Atropine will combat the undesirable effects of Mecholyl and a hypodermic syringe containing 0.6 mg. of atropine should be readily available at all times. Mecholyl is contra-indicated when there is a history of allergy, asthma, hyperthyroidism, recent coronary occlusion, or severe illness.



THE NURSE and TIPS

A frank discussion of the tipping problem in hospitals

■ ONE NIGHT last fall, the professor of our writing course asked me to read one of my short stories to the class. It was a story about a nurse-patient relationship in which a sensitive, sympathetic nurse tried to give courage to a patient facing a serious operation.

In the ensuing discussion period, one of the younger members of the class commented, "I don't think it's a realistic story because the nurse is not like any nurse I've ever seen. Most nurses won't do anything for you unless you tip them first." From the rest of the room—there were about forty students in the class, ranging in age from eighteen to fifty—came a murmur of assent.

Then a voice boomed from the back of the room. "You're wrong about that." It was the one doctor in our class. He stood up and for five minutes delivered a sincere defense of nurses, saying how hard they worked, how there was often little thanks for what they did, and how, in his opinion, they deserved the highest admiration.

This started me thinking, and then about a month later, another incident occurred. I was assigned to the orthopedic ward one morning, and one of the patients on my bath list was a man who had been brought in from a suburban hospital the night before. As I went about his bath he had little to say, though I noticed that he was watching me closely. When I had his bed made, I moved his bedside table where he could reach it, raised the head of his bed, and asked him if there was anything else he wanted.

He looked at me skeptically, "Do you mean you do this for nothing?"

"Not for nothing," I said, not quite knowing what he was getting at. "We get paid."

"But you don't expect the patients

by Evelyn T. Pastore, R.N.

to tip you—to give you something extra?"

"Of course not," I exclaimed defensively.

"Well, this place sure is different from the hospital out in ....." He mentioned a town outside of New York City. "Out there the nurses won't do anything for you unless you tip them first. Before anything is done for you, you pay."

I could scarcely believe his story, and even now I find it incredible. But he was a simple working man and seemed honest. I remember that he said to me, "Thank God I was transferred to this hospital. Nurse, I can hardly afford to pay my hospital bills, much less pay individually for each thing that is done for me."

These occurrences illustrate, I believe, how important a problem tipping is. Is it a fact that current public opinion of us is marred by the belief that we are motivated only by tips? Certainly, persons such as the doctor in my class know that we as a group are not motivated by tips or financial reward. (If we are, we certainly entered the wrong field.) But, apparently there are people who feel that nurses are tip-minded. There must be some basis for this conclusion.

And more important than other people's opinions of nurses, is the effect of tipping on us. If my patient's story was true, the situation in that hospital probably grew out of what was originally an innocent acceptance of money gratuities. The pattern of development is easy to imagine. First the nurses accepted tips, next they expected tips, finally they assured themselves of tips by demanding them.

Nurses who allow tips—or if you prefer a nicer term, money gifts—to *determine the quantity and quality of their nursing care* can bring down on all our heads a price tag that most of us would find intolerable. The acceptance of tips makes a ridicule of our claim to professionalism. A profession means that its practitioners subscribe to certain ethical standards that govern the practice of their duties. In several years of nursing, in three different states, and in five different general hospitals, I have known very few nurses who were influenced by anything but the highest ideals in their care of patients *but most nurses I have known admittedly accepted tips.*

It is time our profession took an honest, realistic look at the whole problem of tips. I, personally, don't

think it's a simple problem. I became so interested in the question that I started talking to nurses about the practice. I went to our hospital library and looked up books on nursing ethics (and in my opinion, a woefully sad lot they were, with little use to the nurse of 1953).

For many years, one of the ethical commandments of our profession has been that nurses do not accept tips. Most nursing schools enforce this rule, and students have heard the dictum repeated in the classroom from one end to the other of their training period. Recently, the precept has been enunciated again in the Code for Professional Nurses prepared by the American Nurses Association's Committee on Ethical Standards: "A nurse accepts only such compensation as the contract, actual or implied, provides. A professional worker does not accept tips or bribes."*

As a statement of principle by the top spokesman of U.S. nursing—the ANA—this has a salutary influence. It points the way and perhaps, in the future, phrased as it is (the two simple declarative sentences are statements of fact), it will have validity. I have never known a nurse who let herself be bribed, unless acceptance of a gift or tip while the patient is under care is a form of bribery, and I imagine many nurses refuse money whenever it is proffered. ***But many more, do not.***

"Many times," a conscientious young nurse said to me, "a $5 tip will tide me over until pay day, and I don't mind saying that I'm glad to get it." Honesty is only one of her virtues. No one who knows her could doubt her genuine nursing spirit, her ability, or her professionalism. What this nurse had to say about her sentiments on tipping reflected a general opinion which many nurses voiced.

The same nurse told me that one day while she was admitting a wealthy patient to her floor, the patient's husband offered her $10. She thanked him, but refused. Later, when she returned to the nurse's station she found a $10 bill protruding from the blotter on her desk. When none of the other nurses on the floor could account for it, she followed her hunch and took it down to her new patient's room. She returned the money and once again thanked the patient's husband, but this time she added, "We have a number of patients to take care of, and we care for everyone as well as we can. Your wife will receive all the attention we can give her, but I can't take this money." The husband was extremely surprised and stated that in other hospitals the nurses seemed to expect tips.

While telling this story, the young nurse expressed indignation that nurses would accept tips prior to discharge. Her way of expressing it was, "To me, tips represent a way of saying 'thank you.' The patient is grateful for the care you've given him. Rather than buy a gift you might not want, he gives you money to buy and select something you do

*In July, 1953, the International Council of Nurses also adopted a Code of Ethics, including this same principle, but without definite reference to tips and bribes.

want. But to take money from a patient you're admitting or taking care of—how can you and the patient have the right kind of relationship?"

On the question of tips, most nurses have worked out a code of their own, one that is fairly widespread it appears to me. A tip or money gift represents a way of saying "thank you," and is acceptable only when the patient is leaving the nurse's care. How it is presented is important. Preferably, it is in an envelope with a note of thanks, although many nurses express a certain embarrassment at accepting an envelope that quite obviously contains money. More important is the patient's attitude. Many nurses will refuse a tip from a patient with whom they haven't had amicable relations, for they feel that the patient can only be giving reluctantly.

In many instances, the patient's feelings must be considered too. Refusing a tip is sometimes tantamount to a personal insult. I had an experience like this myself. I was taking care of an old woman who was very sick with leukemia. She was a private patient but since she had only a small income a sister was footing her hospital bills. I was very fond of this patient; I liked her courage. One day when I finished her bath, she slipped some coins into my uniform pocket. I quickly removed them and handed them back to her. "Please," I said, "Don't do that. You

Probie

"Anything for Thanksgiving?"

know I'm delighted to do anything for you that I can." The expression on her face changed. She was not only angry but hurt. "Take that money," she said, "or never take care of me again." I was dumbfounded. Then she softened, "Get yourself an ice cream soda," she said in a quiet voice. Every time I took care of her thereafter, she dropped fifty cents into my pocket with the same advice, "Get yourself an ice cream soda." Need I say that I never tried to return the money? She did the same for other nurses on the floor and any normal resentment we might have had against the practice was overlooked—in true nursing spirit, I believe—because it gave her a sense of independence to give from her limited funds.

The patient's desire to show his appreciation to the nurse springs up rather naturally, I feel. The relationship between nurses and patients is often close, personal, and prolonged. During a difficult time in the patient's life, he is dependent on the nurse not only for the care that will make him well, but for many personal services that he would normally perform for himself. Often the patient observes that the nurses do things for him that he normally rewards with a tip: mailing a letter, fixing flowers, telephoning, etc. And although the patient receives his hospital bill, his doctor's bill, and is charged for other tests and treatments, what of the nurses who care for him around the clock? Except in cases where special nurses are employed, charges for nursing service are hidden in a general hospital bill and the patient feels that he is not paying for his nursing care.

Besides the patient's feeling that he hasn't paid the nurses directly, there may be the knowledge that nurses' salaries are not commensurate with the nature and responsibility of their work. The effects of low income on the tipping problem are manifest in the statement of another nurse I talked to. "After three years of training and three years of general duty, I have a take-home pay of under $60 a week. My kid sister took a secretarial course in high school and is already earning $75 a week. If my salary were higher I might not be interested in tips." This is in New York State where nurses' salaries are higher than in many other states.

From my observations, the interesting factor in tipping is that there is often little correlation between service and tips. Tips correlate more frequently with personality. Many a hard-working, conscientious nurse has been heard to say, "What's the matter with me? Why don't I get expensive gifts or generous checks?" Being human, she can't help but be a little jealous of her less industrious co-worker who is the constant recipient of patients' generosity.

There are methods—fairly well-known ones—to induce the patient to reward you for your interest and care. There is no need to summarize them here. It is more important to consider ways of putting a halt to the practice of nurses' accepting tips or rather, [*Continued on page* 81]

AN OPEN LETTER ON HUMAN DIGNITY

DEAR EDITOR:

When does an individual acquire human dignity? When the individual reaches the age of eighteen, twenty-one, the age of reason? I am probably old-fashioned, but I thought it began at birth.

The experience that brings forth this outburst is one that makes me ashamed for some of my fellow nurses and for others who are entrusted with the care of helping the sick.

My little five-year-old daughter, Janet, has recently been seriously ill with what was at first believed to be leukemia and later diagnosed as an acute bone marrow depression due to the administration of chloramphenicol (Chloromycetin).

The establishment of this diagnosis meant that we must go to a well-recognized children's hospital where laboratory and medical facilities would be available. It was here that the question of human dignity arose.

Whenever a test (and there were many of them) was to be taken, three or more individuals, led by the head nurse, would descend upon Janet, hold her down, and proceed without further ado. Naturally, she rebelled at this barbaric attitude and so did I, but I had to "keep out of the picture" for fear they would "take it out" on her.

It was also necessary for Janet to have a complete skeletal x-ray to rule out lymphosarcoma. The x-ray technician came into the room, and without saying a word to the youngster, picked her up and put her on the same [*Continued on page 78*]

Ewing Galloway

Problem of Emotional Trauma in Hospital Treatment of Children*

■ THE IMPORTANCE of the emotional needs of the child in the hospital, and especially of the child who is to be operated on, has been receiving more attention in recent years by nurses, pediatricians, surgeons, and psychiatrists. The fact that emotional trauma occurs is widely accepted. The definition of the term, however, and the causes and means of prevention of the condition are sometimes inadequately understood. For the purpose of this discussion, emotional trauma will be defined as the intensification of any feeling that may be deleterious to a satisfactory adjustment to life. Feelings that are likely to be involved in the hospital treatment of the children are anxiety, suspiciousness, resentment, hostility, inadequacy, insecurity, and a desire to retaliate.

From our study of the psychological aspects of hospitalization, anesthesia, and surgery in a group of children, certain conclusions seem justified concerning the nature, etiology, and prevention of emotional trauma associated with such experiences. The children, whose ages ranged from 3 to 8 years, were ad-

*Abstracted from an article by Katherine Jackson, M.D., Ruth Winkley, A.B., Otto A. Faust, M.D., and Ethel G. Cermak, M.D., in the *Journal of the American Medical Association*, August 23, 1952.

mitted to the hospital for tonsillectomy. Before admission, a psychiatric social worker interviewed the mother and the child in the home, obtained a record of the child's behavior, and evaluated his emotional characteristics and his relationship to his parents. A history of dreams and mannerisms was included in an attempt to elicit the presence of repressed feelings. This interview was repeated several times after the operation. Final checks after 18 months are now being made. In most of the children, anesthesia was administered by an anesthetist with special interest and experience in dealing with emotional problems.

In this age group, traces of some or all of the negative feelings under consideration are already present. They exist in varying degrees in every child. Thus, it is impossible, at this age, to initiate a new negative feeling by any single experience. Even as threatening an incident as hospitalization and surgery is merely another feeling-experience. It is the combined responsibility of parents, physicians, and hospital personnel to make it a constructive experience or at least to keep its emotional damage to a minimum. In the prevention of emotional trauma in the hospital-anesthesia-surgery experience, there are three important factors: 1. The child must have made a reasonably adequate adjustment to his environment. 2. He must have proper preparation for the specific experience. 3. The experience must be modified to meet the child's endurance. The first of these factors, the adjustment of the child to his environment, depends almost entirely on the relationship between the child and his parents. If he has been wisely loved and adequately supported, he will be trusting and self-assured. If his parents are suspicious or retaliatory, he will be likely to follow this pattern. Just as his physical traits are determined by those of his parents and grandparents, his emotional make-up will largely parallel that of his forebears. The difference is that, while purely physical characteristics are modified only by generations of evolution, any parent can learn to understand and improve his feeling-pattern and pass on to his child a different set of emotional reactions from those he learned from his parents. The importance of this principle lies in the fact that the emotional equipment required for dealing adequately with a hospital experience is no different from that needed in dealing with the other problems of life.

Our experience has shown that the child best able to meet the hospital-anesthesia-surgery situation is the child who is able to trust the physicians and nurses to treat him fairly. He assumes that painful procedures are necessary, are for his own good, and are not punitive. He is willing, therefore, to place himself in the hands of others and expects from them the kindness, understanding, and support to which he is accustomed at home. He is not overwhelmed by his own fear, because he is able to trust someone else who is unafraid. Obviously, such a child must have a firm foundation of trust

in his parents, a deep assurance that they are always fair and always consistent in their love.

With such a background of preparation for all difficult experiences, preparation for hospitalization is simple. The parents should explain honestly and simply what is going to happen and why. The child's questions should be answered patiently and reassuringly. It is important that the parents avoid communicating to the child any apprehension that they may have. On the other hand, the child's fear should be accepted as normal and be neither denied nor ridiculed. In other words, the child should be allowed to be frightened but should be able to look to the adults and find them adequate and unafraid.

The time of admission to the hospital for elective procedures should be determined with regard to the child's emotional state. In case of a death in the family, especially that of a parent or a sibling, or serious marital difficulty between parents, operation should be postponed until the child has made his best adjustment to the situation. Time should also be allowed for his becoming accustomed to school, a new home, a new baby, or a new stepparent before he is sent to the hospital.

Shortly before admission to the hospital, either the family physician or the surgeon should tell the child what is going to be done. If, along with tonsillectomy, any other procedure, even the removal of a tooth or a wart, is anticipated, this should be explained.

For even the best-prepared child, and especially for the anxious one, considerate treatment in the hospital is necessary if emotional trauma is to be avoided. It might seem that busy nurses and physicians could not possibly meet each child's emotional needs, and it is true that they cannot perfectly replace the parent, but children who have been loved wisely at home develop a self-assurance that makes them less demanding. They need only considerate understanding and they will cooperate. Specific examples of desirable means of administering treatment could be given, but the important factor is the feeling of the adult toward the child, for [*Continued on page* 65]

You may have noticed that our October issue was Volume 16, No. 13 and this issue is Volume 16, No. 14, rather than the first and second numbers in a new volume. To make it easier to bind *R.N.*, Volume 16 will continue through December (containing fifteen issues instead of the usual twelve), and Volume 17 will start in January and continue through December, 1954. We believe this change will make it easier for librarians in the many institutions and agencies who are now binding *R.N.*

CANDID COMMENTS: *The Need for Statesmanship*

■ IN THIS ARTICLE, I wish to point out the imperative need for professional nurses to study not only the caliber of the individuals elected to the boards of our nursing associations, but also to learn what to expect from them, and what is nurses' relationship to them. Nursing has come up the hard way—we have had to learn through trial and error, for we had no precedents or blueprints. In the days before organized action carried the power it does today, we nurses were easy going in our selection and election of trustees. Some were re-elected for fifteen- and twenty-year stretches simply out of habit or because they were famous names, and some because we wished to honor a respected veteran. And once elected, the whole responsibility was theirs—the membership offered little in the way of checks and balances.

Janet M. Geister, R.N.

Today we must learn a new way. Nursing has grown up to make for itself a unique and valued place in the life of the community, and in the work of the health professions. So vital is it to every health program that our forces have been overwhelmed by the demand for nurses, and we must learn to deploy these forces with greater skill and economy than we have ever known before. We must learn to do this without harming or destroying the intrinsic values in the nurse-patient relationship that make professional nursing distinctive and essential. These values are gravely threatened today as more non-nurse authorities decide what the auxiliary nursing aides may do. It is tragic that this division of duties was forced upon us before there was time or opportunity to learn by experiment where lie the zones between professional and non-professional nursing.

Today we must learn how to work with our allies in hospital and health administration, and in medicine, not as a subordinate group with a tale of woe, but as partners whose ideas command respect. We must learn how to function as a major community service with other agencies. We must learn how far we can go in sharing with other groups decisions in nursing education, legislation, and practice, and how to stand firm and fast at the dividing line. And of paramount immediate importance is our need to establish within nursing a much broader concept than now exists of the whys of our present situation, and the wherefores of what we must do. At this time, we are a "house divided against itself" in a number of major areas, notably in the use of auxiliary nursing aides. [*Turn the page*]

In our critical hour of transition and readjustment, none of us can escape the duty to learn more, do more, think more, for the profession. But all of us are dependent for guidance on the policies and plans set up by the governing bodies of our professional associations. That is why we have associations and governing bodies. Without them we would be formless and helpless before a world that works almost wholly through pooled effort. As our associations must meet the increasing conflicts of a highly competitive world with greater skill and more clearly defined purpose, we must more and more rely upon the wisdom and intelligence of our boards of trustees.

As our associations grow in size and activities, the individual member loses place in proportion, and again must depend upon elected boards to represent her hopes and ideals in all actions, and to protect her interests. In the handling of money alone, the sum total of our associations' budgets, local, state, and national, reaches a huge sum. In the nature and number of new issues to be faced, the "budget" is even greater.

In electing trustees or directors, we delegate to them *our* power of decision—and today we invest them with a power that has never before been so potent. To serve them are professional staffs, office machinery, and public information facilities in a degree never known before. Regardless of our individual opinions, it is these members of the board who mainly mark the paths and set the pace for the profession. Whether or not we are members of these associations, we rise or fall through their plans and actions. While for professional nurses, the house of delegates or convention body is the supreme authority, the fact that they meet at best but once a year—nationally once every two years—places much of the actual governing power upon the board of trustees.

Today we have to learn how to cut across old habits, old inertias, inadequate systems of nominations and elections, to find ways to bring our finest leadership material out into actual leadership. But our duties as members do not end with the election. We have to understand how we can help our trustees and what to expect from them. We must have accountings of action and expenditures that all of us can understand. This calls for a wholly new philosophy on our part. Once we understand that the trustees are *our* agents, and not elevated beings apart from us, we will do less footless griping about what "they" do, and think more in terms of what "we" do. We will become less reluctant to put our questions and ideas squarely to our elected representatives. Any communication from any member addressed to *the board of directors* merits the respectful attention of the board—and any move to the contrary should be energetically challenged by the membership.

The subject of trustee responsibility is getting unprecedented attention today in many areas of business,

industry, community, and the professions, as organized effort becomes more important in our lives, and as busy people must delegate more responsibility to boards that act for them. The stockholder's or member's isolation from actual participation in or knowledge of affairs is further increased by the growth of paid staffs that take over the administration of the program. This isolation, especially in large associations, always makes it possible for a staff or a clique on the board, or both, to gain an almost impregnable control through self-perpetuating or committee appointments methods. We have seen instances of executives grimly hanging on to prerogatives that belong to the board—and instances of boards putting so tight a rein on the executive that she cannot function. We have seen instances of action programs sharply out of line with actual needs and also instances of grossly unjust treatment of staff personnel.

These maladjustments are due more to fuzzy or obsolete concepts of trustee obligations than to anything else. They point to the crying need for education in these obligations by thoughtful and responsible trustees. I look forward to the day when the trustees of all our institutions will have to measure up to more clearly defined standards than now prevail, and when short courses

Beatitudes of a Leader

"***Blessed*** **is the leader who has not sought the high places, but who has been drafted into service because of her ability and willingness to serve.**

Blessed **is the leader who knows where she is going, why she is going and how to get there.**

Blessed **is the leader who knows no discouragement, who presents no alibis.**

Blessed **is the leader who knows how to lead without being dictatorial; true leaders are humble.**

Blessed **is the leader who seeks for the best in those she serves.**

Blessed **is the leader who leads for the good of the most concerned, and not for the personal gratification of her own ideas.**

Blessed **is the leader who develops leaders while serving.**

Blessed **is the leader who marches with the group, interprets correctly the signs of the pathway that leads to success.**

Blessed **is the leader who has her head in the clouds but her feet on the ground.**

Blessed **is the leader who considers leadership an opportunity for service.**"

in the principles of trusteeship will be available. Trusteeship is too powerful a tool in the shaping of progress and the establishment of justice to be left to haphazard standards. We see this trend in financial literature where writers give increasing stress to management's obligations to stockholders. In *This Hospital Business of Ours,* Raymond Sloan speaks plainly of hospital trustees' responsibilities that too many either ignore or have never learned.

This literature pleads for new approaches that include objective evaluation of the corporation's activities and a greater sharing of information with the members. These ideas have meaning for us. Nursing, in its endless eagerness to fulfill its duties to society, has promoted outstanding surveys of its works. But these have related to education, practice, nursing economics, and organizational structure—not to objective appraisals of our action programs and our methods of achieving them. Boards, or their dominating groups, are extremely sensitive to any suggestion of inadequacy in program or internal policies. But the need for skilled and impersonal appraisal is being increasingly recognized. "Management, both good and bad," writes Jackson Martindell, president, American Institute of Management, "plays a vital part in institutions of learning, religious groups, charitable institutions, and, in fact, in every form of organized effort." The Institute's "36 basic rules for boards of directors" have many implications for nursing.

The need for sharing more of board discussions and action with members cannot be overstressed. We have improved much in this respect in the past few years but we still have a long way to go. A district member asked one of her trustees what action had been taken on a certain matter. "Sorry, I can't tell you," was the reply. "One thing that's told us time and again at board meeting is that what we do must remain confidential." [*Continued on page* 72]

Prayer

God, touch my hands with tenderness,
For many folk today
Have never known Thy gentleness
And kindness; so I pray,
Oh, teach my fingers carefulness;
Make their touch warm and true,
And as I'm waiting on the sick,
Lord, keep me serving You.

by Lois Rowe, R.N.

Pray for Your Patients

by Reverend Graham R. Hodges

■ THE GREATEST physicians acknowledge that it is God, through the mysterious processes of nature, Who really heals the sick. Doctors and nurses may provide the proper conditions for recovery, but God restores the ailing tissue.

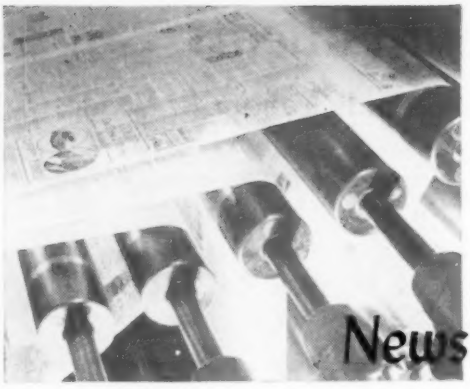
Surgery, antibiotics, good nursing care, proper food, oxygen tanks—all these and more, too, are accepted as routine aids in the care of the sick today. They represent the physical paraphernalia in our modern hospital's healing mission. In addition, there is the atmosphere of concern and love which every good institution manifests, and which helps so much in a patient's recovery.

As a minister, I have close contact with many patients before they come to a hospital, while they are there, and after they return home. Here is a bachelor, who lives alone, cooks his own inadequate meals, and tends his house in his own way. In the hospital for minor surgery, he is shown personal attention for the first time in years. Though most hospitals now simply can't afford to have nurses become mere morale-builders, this kind of patient responds wonderfully to "TLC." Another patient is a middle-aged-woman who took care of an invalid mother for seven years until her health broke under the strain. In the hospital with pneumonia, she gets as much benefit from the personal attention as from the drugs.

In addition to the actual physical care and personal interest, I believe the nurse can help each patient under her care by the simple method of prayer. Prayer! Why, what nurse has time for prayer, some might say. We're doing well if we get the patient's physical needs tended to. Let the visiting clergy handle their spiritual needs.

This reaction is a natural one, in view of the nurse's multitudinous duties today. It also is a natural one in a day when we rely so heavily on pharmacology for treatment, forgetting that over half of a doctor's cases come to him because of psychogenic factors. Our troubled minds and souls wreak havoc with our livers, stomachs, colons, hearts, and lungs.

So, as the R.N. goes among her patients, she is not just attending appendectomies, tumors, cardiacs, and strep throats. She is attending incredibly intricate human beings, many of [*Continued on page* 70]



News in Review

▶ *LONG A RUMOR*, but now bona fide news, is the announcement by Basil O'Connor, president of the National Foundation of Infantile Paralysis, that plans are going forward for large-scale testing of a polio vaccine. Such a test, involving the vaccination of hundreds of thousands of children during a non-epidemic period, will be launched as soon as plans are completed—probably in the early part of 1954. The validity of the vaccine should be determined by observing what protection resulted when polio outbreaks occurred in the communities of the vaccinated children. Mr. O'Conner's statement followed an optimistic report on polio vaccine studies by noted polio-researcher, Dr. Jonas E. Salk.

▶ *NURSES' SALARIES HAVE RISEN* in twenty hospitals in Manhattan, the Bronx, and Staten Island following the new "recommended" pay scale issued by the New York Counties Registered Nurses Association last July. Lucille E. Notter, president of the organization, said that the starting scale for general duty nurses has gone from $225 a month to $250. The new rate is $10 below the $260 minimum recommended by the Association, but Miss Notter pointed out that all the hospitals had already made up their budgets for the forthcoming year before the recommendations were made known. Hospitals in which raises have occurred include Roosevelt, New York, Presbyterian, Lenox Hill, St. Luke's, and Mount Sinai.

▶ *ACROSS THE BORDER:* Speaking at the annual meeting of the Maritime Hospital Association, Dr. Harvey Agnew, Toronto hospital consultant, warned that state control of nurses in Canada may become necessary in order to ensure the "utmost use" of their services. In New Brunswick, for example, fewer than 150 nurses—about one for every thirty hospital beds—were graduated this year. Plans are in progress to increase by one-third the 4,500 hospital bed space now available thereby adding to the already acute demand for R.N.'s . . . Graduates of the only correspondence course in hospital administration in the world were honored at Macdonald College, St. Anne

de Bellevue, Canada, this July. The two-term course is sponsored by the Canadian Medical Association under a grant from the Kellogg Foundation. Winters are spent at home studying by correspondence; each summer the students convene for a month's session which includes problem-solving and general discussion. Although the course is open to anyone, the Canadian Medical Association selects the number to be enrolled. Of the 52 students originally enrolled, 32 completed the course.

✓ ✓ ✓

▶ *ATTENTION PRIVATE DUTY NURSES*: The ANA Research and Statistics Unit has been exploring the possibility of securing data on the economic status of private duty nurses from the Bureau of Old Age and Survivors Insurance of the Social Security Administration. However, technical difficulties have arisen due to the manner in which individual nurses report; in many cases it is impossible to distinguish between professional and practical nurses. Private duty nurses are urged to designate themselves as "registered professional nurses" when filling out Schedule C-a (Form 1040)—the form attached to the income-tax return on which the self-employed person reports net earnings, occupation, etc.

✓ ✓ ✓

▶ *CAPITOL COPY*: In the opening address to the fifty-fifth annual convention of the American Hospital Association, Mrs. Oveta Culp Hobby, Secretary of Health, Education, and Welfare, challenged private enterprise as represented by organizations in the field of medicine to rescue the average American family from the financial destruction that threatens when catastrophic illness occurs. Mrs. Hobby asserted that "tuberculosis, poliomyelitis, strokes, congenital defects, cancer, arthritis, and many other diseases, by their very duration can still wreck many a family's economy." . . . The Welfare and Retirement fund of the United Mine Workers of America spent more than $138,963,949 in the fiscal year ending June 30. Of that amount, over $56,444,329 was spent for [*Continued on page* 74]

About People

▶ ***JOHN H. HAYES***, **director of Lenox Hill Hospital, New York City, has succeeded *THERESA I. LYNCH* as Chairman of the Committee on Careers of the NLN . . . The ARC has appointed *MADGE CROUCH* as executive assistant national director, Nursing Services, for the Blood Program . . . *CAPT. LILLIAN DUNLAP, ANC*, Nurse Procurement Officer for Fourth Army, and *LT. COL. NAOMI JENSEN*, Chief Nurse, Brooke General Hospital, are enrolled at Incarnate Word College to study for the B.S. degree . . . After forty years in nursing, *SOPHIE C. NELSON*, organizer of the Visiting Nurse Service of the John Hancock Mutual Life Insurance Company and assistant secretary of the Company has retired. Miss Nelson is also known for her activities in nursing organizations.**

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The Texas TORNADO*

San Angelo's Private Duty nurses' response to disaster

There have been many times in the last few years when I felt that nursing was a lost cause, but the nurses' response to the havoc created by the tornado which hit San Angelo on May 20th restored my faith in the profession.

The call for nurses was by radio to the Fire Department. As the Bureau phone was out of service, they called my personal phone, which promptly went out of service. Rain and hail were falling in sheets and the wind was blowing a gale. Eager to get to a phone which was in working order so I could call other nurses, I donned a bright red coat, grabbed the Kardex file which listed all the nurses registered with the Bureau, and dived into the street to look for a car to drive me to the hospital. I thought a car would never stop, but finally a group of soldiers stopped and took me to the hospital.

Only one of the hospital phones worked, but it was enough. Every nurse we were able to call just ran to the hospital. Forty private duty nurses volunteered for the first two days. By the time the patients began arriving, the emergency service was full of nurses. They came in house dresses, street clothes, and one in a pair of blue and white striped overalls. All of them were very wet and bedraggled, but they rushed to different halls and surgery. Some of them stayed all night and were back by 11 A.M. the next morning. Actually, the whole thing went off like it had been rehearsed. So far there has not been one private duty nurse who would present a bill to a tornado victim even though some of them are able to pay. Of course, the hospital nurses all worked long hours and did double duty, but their salaries do go on. [According to a later report, the hospital offered to pay regular salary rates to outsiders as well as to hospital employes. The offer was rejected, however, and all personnel offered their time and their services as a contribution to the victims of the disaster.]

I do feel proud of our own private duty group. One of our oldest nurses, who works very little because of her health, worked sixteen-and-a-half hours with two critical patients, and then twelve more with one patient. She was furious with us for insisting that she rest one night.

Today, we have nine Red Cross nurses, which has greatly improved the situation. I realize this is an incoherent account, but most of it has been written while the telephone was parked on one shoulder. However, we wanted you to know how your children behave when the "chips are down."

*A personal report to the General Secretary, TGNA, by A. Lou Morris, R.N.

How the greater **Kent**'s Micronite

efficiency of Filter is verified

Until the new KENT cigarette was introduced last year, factual evidence of the comparative efficiency of filter-tip cigarettes did not exist.

Realizing this, the makers of KENT decided to compare the efficiency of its exclusive Micronite Filter with other filters—and to release the findings to the general public.

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These scientific comparison tests show that while conventional filters remove some irritants, KENT's Micronite Filter *approaches 7 times the efficiency of other filters in the removal of nicotine and tars* and is virtually twice as effective as the next most efficient cigarette filter.

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These tests, without exception, show that KENT's Micronite Filter is the first to remove enough of the irritants from cigarette smoke to give susceptible smokers (about 1 out of every 3) the protection they need. At the same time, this filter lets through all the rich taste of fine tobaccos that gives smokers the satisfaction they want.

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Jell-O is a registered trade-mark of General Foods Corporation

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Trauma

[*Continued from page* 52]

those individuals who really have the child's welfare at heart will intuitively choose the least traumatic methods. Lack of experience sometimes leads to minor errors. A student nurse was inadvertently responsible for several days of anxiety in one of our children, because she told him that the catheter through which rectal anesthesia was administered was only "a puppy dog's tail." The child could not remember the catheter being removed. Naturally, not all persons have the emotional maturity, the warmth, or the wisdom to be supportive and understanding; if, however, the child is making a satisfactory adjustment to life in general, he will probably not be seriously disturbed by unenlightened treatment for a few days in the hospital.

The exception to this occurs in separating the very young child from his mother at the time of surgery. When there has been no previous separation, this aspect of the experience is probably the greatest source of trauma. For most children under 4 years of age, it is our observation that no amount of love and understanding will effectively substitute for the mother. When physicians realize how inextricably a child's emotional welfare is bound up with physical welfare, provisions will be made for a parent to remain with the hospitalized child. If only in the interest of physical well-being, a consideration of the child's emotional needs must eventually take precedence over rules, schedules, and the polish on the floor. Certain qualifications must be made to the general statement that a parent should stay with the child hospitalized for tonsillectomy. Since the purpose of the parent's presence is to support the child in a difficult situation, any parent who does not help the child is of no use. In fact, the overanxious parent may add to his child's burden, and, certainly, the parent who overidentifies to the point of hysteria (not a rare occurrence in our study) does the child more harm than good.

In the interest of reducing emotional trauma during the hospital stay, treatments such as enemas and venipunctures should be kept to a minimum. Having anything inserted into the anus, especially by a stranger, is extremely objectionable to most children and should be avoided whenever possible. If the child has learned to hold a thermometer in his mouth, he should be permitted to do so at the hospital. Waking the child at midnight on the preoperative day to take his temperature because the chart calls for a reading seems unkind and unnecessary. A preoperative reading after he has awakened is more informative and less traumatic. Giving unavoidable enemas and taking temperatures are things that can be done by the mother if she is allowed to stay with the child.

Among the children in our group, needles caused the greatest resentment. It was our practice to reduce the use of needles to a minimum, so that we usually were able to protect the child from all but the finger

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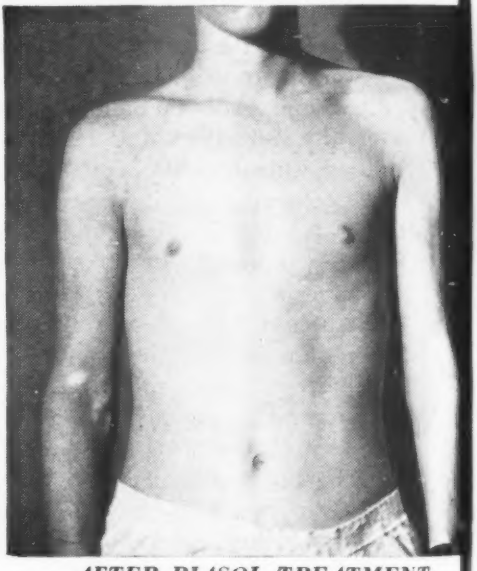

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RIASOL FOR PSORIASIS

prick for the hemoglobin reading and the atropine injection. The latter was given in the arm rather than in the buttocks, because, early in the study, we found that less resentment was aroused when the child could see what was done. Venipuncture for the required Wassermann test was done during anesthesia.

The use of a bed with sides is sometimes taken as an insult by children who have outgrown them at home. It is accepted, however, if the sides are explained as a necessary protection against a painful or dangerous fall. The young patient should not be required to stay in bed, especially alone in a room, when he is feeling well. On the day before surgery, he will be happier and more cooperative if he is allowed to play with other children.

The atraumatic administration of anesthesia poses a special problem. Unless precautions are taken, the child is likely to mistake the onset of unconsciousness for impending death and to struggle accordingly. Verbal reassurance alone is ineffective and must be augmented by specific information about the experience and its sensations.

The inability of children under 4 years of age to understand and anticipate a threatening experience might suggest the advisability of using some form of basal anesthesia. A few of our children were given thiopental sodium rectally, too few to warrant conclusions concerning its efficacy in preventing emotional trauma. It was noted, however, that the children who went to the operating room asleep showed some postoperative anxiety and doubt about whether their tonsils had really been removed. At the time of emergence from anesthesia, the child again has a great need for the comforting presence of the parents. In fact, even if parents are barred at all other times from the pediatric ward, they should be allowed to be present at the bedside of the awakening child. Even under the best conditions, the child has been through a frightening and threatening experience and needs the immediate assurance that only a mother or father can provide.

Most children come to the hospital with less than perfect intellectual and emotional preparation. Deep-seated anxieties and feelings of insecurity and inadequacy make the prospective experience a real threat to their emotional adjustment to life. To these children, physicians, nurses, and other hospital personnel can render valuable aid. They can supply the love and the support that the child must have if he is to withstand the hospital experience without further emotional damage. The child who is anxious and suspicious is the child who will cry and resist the most, and he is the one who most needs kind treatment. It requires emotional maturity and understanding to be "good" to a belligerent, assaultive child, but the willingness and the ability not to retaliate at such a time will pay dividends in reducing the child's hostility and resistance and in the satisfaction of having made a constructive contribution to his emotional well-being.

Insurance Questions

[*Continued from page* 31]

for the same ailment is common among all health and accident companies and its purpose is this: While an ailment such as the one mentioned is likely to recur and may recur many times, the company, for the fee it charges for the insurance, cannot make payment for the same ailment again and again. That is why the reader was asked to do what she would have been asked to do by any company writing that type of insurance. It is the common thing and must be expected. This would not occur, however, in connection with claims for illness or accident which would not be likely to recur.

As an illustration, a certain young man who was very fond of baseball put in a claim for an injury to his right arm; when he threw a baseball, the arm was injured. The company paid the first claim promptly but shortly, they received another claim for the same injury. Apparently, the young man's arm was of such a nature that he could not use it without serious injury each time he threw a baseball with energy. As soon as this recurrent feature was discovered, the company refused to pay future claims and insisted on a rider.

The company's medical authorities, of course, are familiar with those types of ailments or accidents which are likely to recur, and the treatment our reader received must be expected in such cases. The situation referred to is not a weakness in the one company mentioned but

it is common among all those companies which write health and accident insurance.

Our reader also quoted two other paragraphs from the letter received from the insurance company:

"If your disability is of short duration this form should be completed and returned to us as soon as possible *after you return to work.*

"Should your disability extend for more than 30 days, we ask that you *then* complete and return this form as a preliminary report."

The reasons for these requests are based upon the company's desire to make full payment for any claim. That is, if the disability is of short duration, it is better to submit the claim after you return to work because then the company can pay for the full amount at one payment. On the other hand, if the disability extends for more than 30 days, it is then desirable, as the company says, to make a return at the end of 30 days as a preliminary report. This is common practice and in the interest of the insured.

Until a policyholder has had the experience of collecting several claims, it is somewhat confusing to receive unfamiliar requests. Perhaps the best thing to do if any request is not clearly understood is to talk with the agent from whom the policy was purchased and find out why the company asks you to do what seems to you to be unfair in some way.

—by John Y. Beaty

Editor of *Bankers Monthly* for twenty-four years. Recently editor of *Investor's Future.*

Pray

[*Continued from page* 57]

whom are there in bed because of troubled minds or souls.

Nearly all of us believe that God is everywhere; that he hears our prayers if they are sincerely expressed; that he answers our prayers in his own way and time; that he can hear us no matter when we pray.

I am not recommending a prayer meeting as each shift comes on duty, although that might not be a bad idea. No, I have in mind something simpler.

Just before you step through the door of a patient's room, silently ask God to be with him, to enter his heart and mind, and give him the strength he needs at the moment. This takes only a brief moment—to concentrate on him, to put his face in your mind, and to ask God's blessing upon him. Perhaps you know that in addition to a broken hip he is being forced to mortgage his home to pay for his hospital bills. Yesterday the lawyer was in the room to make the arrangements. You can't pay his bills, or mend his hip more quickly than Nature allows. But you can ask God to stay beside him in the midst of his present troubles. He can do things that cannot be done by either you or the attending physician.

Remember, your patients are human beings who happen to be in the hospital rather than hospital patients who happen to be human beings. Their most basic needs are spiritual and mental. Their inner state has tremendous influence on their physical condition. Hence, the need for God's presence in their lives and his influence upon those innermost fastnesses of the human spirit which control our outward conduct and even our physical health and well-being.

A short prayer uttered for each patient need not take any extra time. It can be done while walking down the corridor, while passing a door, while making a bed. It can become as fixed a habit as shaking down a thermometer. And it will affect, in a wonderful way, the nurse's own attitude toward her patients. Try it.

*Pastor, First Congregational Church, Ticonderoga, N.Y.

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one of the most frequent symptoms for which the patient seeks medical attention."[1]

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...relieves the cough due to colds
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FORMULA:
(4 cc. teaspoonful)

Neo-Synephrine® hydrochloride	5.0 mg.
Thenfadil hydrochloride	4.0 mg.
Codeine phosphate*	8.7 mg.
Potassium guaiacol sulfonate	70.0 mg.
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DOSAGE:

Adults—1 or 2 teaspoonfuls every two to four hours, not to exceed 5 doses in twenty-four hours.

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1. Banyai, A. L.: Management of Cough in Daily Practice, *J.A.M.A.*, 148:501, Feb. 16, 1952.

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Candid Comments

[*Continued from page* 56]

Again, one of the board trustees spoke sharply to the executive secretary of a state association—"What we do in board meeting is none of the members' business. They elected us and they can leave things to us." Such high-handed attitudes have no place in our associations. Every member has every right to know everything that is done or being done in her behalf by the trustees. The exception to this is premature announcements that might spoil what's on the fire. "The average stockholder," writes Pearson Hunt, professor of business administration, Harvard University Graduate School of Business, "desires a sense of belonging to the organization—a feeling that management recognizes that its powers derive from him." Confidence in management is the basis of all sound investment—a truth to keep in mind in planning membership campaigns.

In my opinion the greatest single test of a trustee's fitness is her ability to stand by her convictions—convictions evolved from study and analysis, not prejudice—even if all alone. I believe profoundly that we elect members to our boards, not for the purpose of "going along with management," or for achieving "harmony" through conformity, but primarily to bring the best of their minds, spirits, and consciences, plus the fruits of their experience, into every decision made. "When harmony comes in at the door," said a

wise man, "progress flies out of the window." Minority opinion is absolutely essential to progress, and "going along with the crowd" can be a poor way to serve the membership. The trustee has a moral obligation to disagree when she cannot in clear conscience agree.

Being a good trustee demands a good deal of the individual in time, energy, and often, purse. But let no one adopt a martyr attitude for whatever "sacrifice" she makes. No one drafts anyone into running for office. We know the costs of serving. Whatever may be her purposes in running for office – self-aggrandizement or service—once elected, the trustee is under inexorable duty to give what the job takes, and give it in a spirit of humility, self-searching, and everlasting learning.

Our profession is infinitely richer for the unpaid services given by our trustees. By and large they have been, and are, highly conscientious people. What we need today is not a greater devotion, but a greater awareness of the newer, broader, more potent responsibilities of trusteeship. We need to figure out more just what it means to be a good trustee—it means statesmanship of a high order.

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News

[*Continued from page* 59]

hospital and medical care benefits. By the middle of 1955 it is expected that ten new UMWA hospitals will be in operation in Kentucky, West Virginia, and Virginia . . . The Internal Revenue Service has ruled that the market value of blood cannot be deducted by blood donors when computing income tax payments. Blood transfusion is a personal service on the part of the donor rather than the transfer of a commodity; services rendered to charitable causes are not deductible . . . In accordance with the recommendation of President Eisenhower, it is expected that Social Security coverage will be extended in 1954 to include numbers of self-employed persons now excluded from the system and that coverage will be mandatory. Strong opposition to this plan has been voiced by the AMA.

▶ *NEWSLINGS*: Statistics recently released by the USPHS reveal that in 1910 there were fifty-five nurses in the U.S. for each 100,000 persons. This ratio had increased to 249 by 1950. In that year one out of every 400 persons in the country was currently employed as a nurse. . . . Clara Maass Christmas seals, issued by the Lutheran Hospital Association of New Jersey, are now on sale. Proceeds from the seals will be used to support the work of the Association, which includes building a new $4,500,000 hospital to be called Clara Maass Memorial Hospital.

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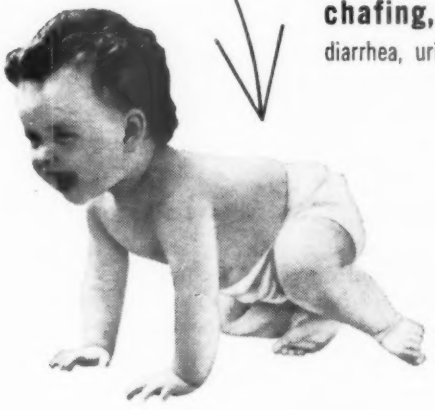
in **extensive dermatitis, diaper rash, severe intertrigo, chafing, irritation** (due to diarrhea, urine, soaked diapers, etc.)



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1. Klarmann, E. G., Wright, E. S., and Shternov, V. A.: Prolongation of the Antibacterial Potential of Disinfected Surfaces. Applied Microbiology 1:19, 1953.

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Meditorials

watch out for propwash! The Reduction in Force (RIF) program of the Air Force has added gray hairs to many a worried head—especially to the head of the AFNC who has the unhappy task of notifying 131 designated nurses that they are to be separated from the Corps—voluntarily or involuntarily. As these AF nurses go off into the cold blue yonder, the human relations or public relations aspect of the move is not being underestimated. It may easily be impossible to woo them back if and when needed—or others in their place. And if the budget axe swings over the ANC—there is no reason to believe it won't—look for a repetition of 1945—and a large group of disillusioned nurses forever bitter against the Service. Memories are long, and wars and police actions appear to be occurring much more frequently.

in a deep brown study *Has anyone else noticed the current vogue among our nurse educators, in their platform speeches, to tend to substitute the more euphonious "Carnegie Study" for the browbeaten "Brown Report"?*

a dramatic revelation Not skeletons, but well preserved minutes books dating back to 1904 were revealed when a certain Texas district, during the process of renovation, pulled out a wall in its district headquarters. Exciting as the discovery was, we can't help but feel for the officer who in 1906 caused the following to be reported in the minutes: "The election of officers had to be postponed because the secretary lost the ballots on her way to the meeting, and for that reason should not be considered eligible for re-election."

Human Dignity

[*Continued from page* 49]

type of cart which had taken her to surgery several days previously.

I had told her that she was to have some pictures taken, and she had been x-rayed in another hospital without difficulty. This time it was different. When she was placed on the x-ray table, one technician (wearing leaded gloves) approached her from behind and began holding her head while another held her feet. All of this without one word of explanation! As could have been expected, the child associated this with her previous surgery and anesthesia and began to scream. The technicians gave up in disgust, saying she would have to be sedated.

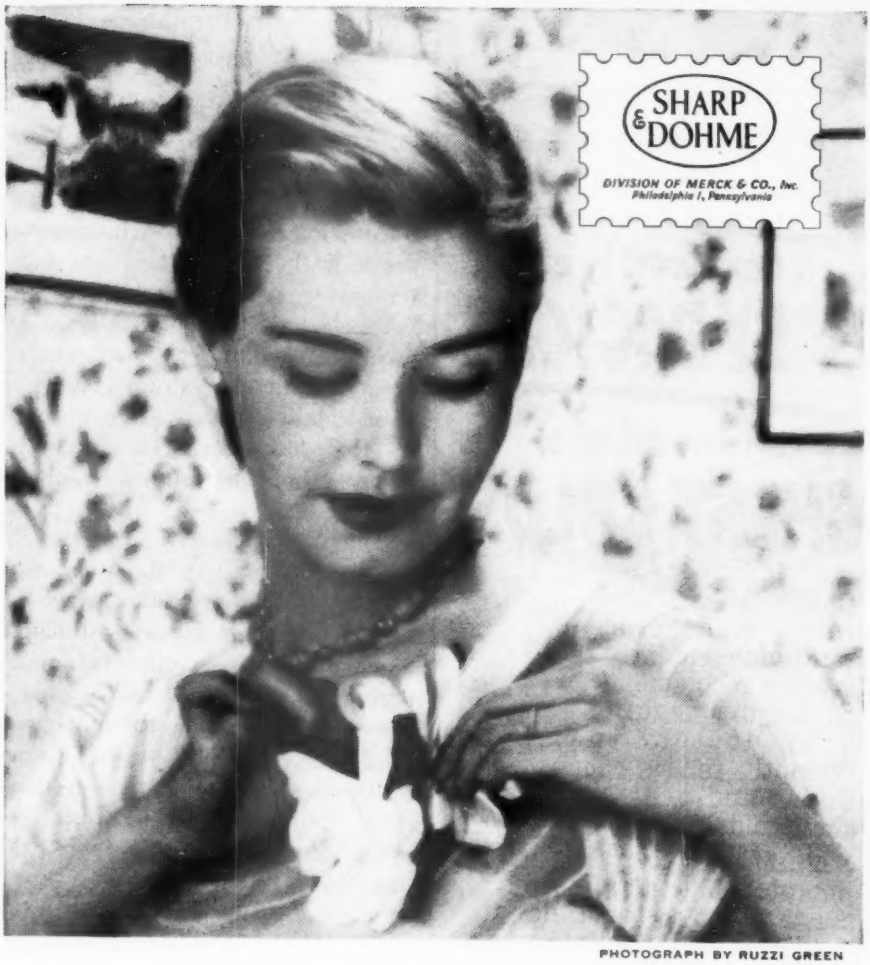
At that, my control reached the breaking point. I told them that had Janet been properly treated this would not have happened. This was confirmed the next morning when the complete series was taken without as much as a word of complaint. I had explained what was going to happen and suggested that the series be started with the legs, thus leaving x-ray of the head until last.

Since then Janet has had blood tests, requiring either pricks or venipuncture. She willingly puts out her hand or arm without question (as she had done before with a reasonable explanation).

Surely other children and even adults are undergoing such traumatic experiences because some members of our profession forget that each person is an individual with a dignity that God bestowed in the act of creation and should be accepted as such.

This has been left unsaid for some months as I knew I was emotionally upset and I wanted to see it in the proper perspective. However, I still find it necessary to arrive at the same conclusion. Our profession is a profession built on serving humanity. It is the place of the nurse to take the leading role and correlate all functions of the hospital team for the benefit of the individual patient. If we lose sight of the dignity of the individual, we will no longer be a profession—nor should we call ourselves professional.

—Mildred E. Dorffeld, R.N.



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COMPOSITION: BO-CAR-AL Hygienic Powder contains boric acid, potassium alum, phenol, oil of eucalyptus, methyl salicylate, thymol and menthol.

DIRECTIONS: As a douche—dissolve 2 teaspoonfuls of BO-CAR-AL powder in one quart of warm water.

SUPPLIED: In 4-oz. and 1-lb. bottles.

Cardiac Arrhythmias

[*Continued from page* 41]

of necessity, have a rest period, and during this rest period, pulse, blood pressure, and circulation are at a standstill. Not only giddiness but unconsciousness and convulsions may occur if the rest periods last more than a few seconds. Fortunately, the ventricle eventually establishes its own beat and the patient recovers. Sympathomimetic drugs such as ephedrine are usually given to speed up the slow heart. They may be taken prophylactically as well as therapeutically.

The importance of accurate observations regarding the pulse rate and the rhythm and intensity of the heart beat cannot be over-estimated. Since arrhythmias often occur in paroxysms which may be of only a few minutes duration, the nurse may be the only one in a position to describe the episode. Although diagnoses depend, in many instances, upon the electrocardiograph, the nurse may, through her observations, supply the doctor with a clue to the nature of the arrhythmia or an indication of the patient's progress toward recovery. If a patient with a serious cardiac condition suddenly exhibits a rapid heart beat, the nurse should know that ventricular tachycardia may have developed and that the doctor must be reached at once. In the successful treatment of the cardiac patient, nurse and doctor form a partnership in which each has an extremely important role to perform.

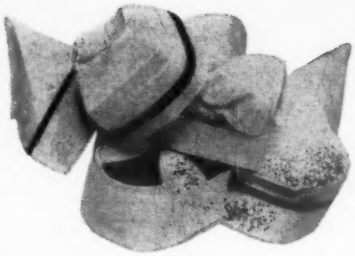
Nurses and Tips

[*Continued from page* 48]

to the practice of patients' offering tips.

Airlines have practically eliminated tipping of their personnel by simple signs forbidding it. I cannot imagine most hospitals taking an action like this since so many hospital employes depend on tips to supplement low incomes. The dilemma of hospital administration on this subject arises—as do most of its problems—from the inability to tally operating costs with income. Administration can only attract sufficient personnel by permitting tipping. Can it take action on tipping solely against the nurses? As pointed out above, many nurses count on an occasional gratuity to boost their rather low incomes, and naturally, most hospital administrators are reluctant to take any action that might accentuate the nursing shortage in their own institution.

What then is the solution to the tipping problem? Should hospital administration work out a system whereby tips are pooled among the nursing staff, or donated to a worthy nursing cause? Or should there be a blanket injunction against all tipping of hospital personnel? Frankly, I don't know. I do know, though, that nurses can no longer pretend that tipping doesn't exist. It does exist and it is becoming more virulent. And unless we strive to combat it, it will continue to tarnish our professional reputation as well as our professional ideals.



Positions Available

ADMINISTRATORS: (a) Pediatric hosp., univ. town, So. (b) Gen. hosp. 60 beds, resort town, Mich. RN10-1 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ADMINISTRATORS: (a) Lovely NW metropolis, "U" center, 157 bed vol gen'l hosp. on Puget Sound. (b) New small MW hosp., RN with adm. ability, full staff cooperation. (c) Adm. also Anest. small hosp., delightful small city, spend winter in Fla. and work. Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

ANESTHETIST: Registered Nurse with 3 or more years experience. Salary $461.50. Laundry furnished, 40 hr. week, 2 week vacation, 12 days sick leave, 7 paid holidays annually. Anesthesiologist in department. 280 bed hospital. Apply Personnel Director, Pontiac General Hospital, Pontiac, Mich.

ANESTHETIST: Starting salary $350 mo. Methodist Hospital, 6th St. and 7th Ave., Brooklyn, N.Y. SO 8-6000, Ext. 142.

ANESTHETIST, NURSE: One vacancy available in modern Westchester hospital, half hour from New York. Excellent surgical staff, pleasant living quarters, schedule shared with 2 other nurse anesthetists allows liberal time off. Chief of department outstanding diplomate in anesthesiology constantly available for consultation. Salary open. White Plains Hospital Association, 41 East Post Road, White Plains, N.Y.

ANESTHETIST-NURSE: 60 bed general hospital, new building, modern equipment, western Wisconsin, college town. Vacation, sick leave, retirement plan. Apply to H. C. Guntner, Manager, Memorial Hospital, Menomonie, Wis.

ANESTHETISTS: (a) Hawaiian paradise, 390 beds, two hosp., Civil Service rank, no exam. req. $4650, mtce. or $42.50 mo. (b) $6000, vol. gen'l hosp., 425 beds, 40 hr. week, call every 5th week end, two days off that wk. to make up. 1 hr. to N.Y.C. (c) 100 bed gen'l hosp., famous heart of Rockies area, twn of 26,000. $4800 to start, inc. very rapid, excellent pers. policies. (d) 14 man staff, 5 OR rooms, no P.O. recovery rm. at present, will add. Sod. Pent. chief Anes. (e) New 80 bed gen'l hosp. $4800. Scenic twn. Northern Cal. Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

ANESTHETISTS: A.A.N.A. member. 250 bed general hospital, salary open, automatic increases, laundry provided, 40 hr. week, no obstetrics, liberal vacation and personnel policies, Social Security. Sutter Hospital, Sacramento, Calif.

ANESTHETISTS: (a) Two. Anes. group, coll. town, E. (b) Foreign operations, lge. indus. co. $8100 which includes living allowance. (c) Fairly lge. hosp. Pac. Islands. $4713. Quarters. (d) New hosp. 350 beds, Pac. Coast. $400-$500. (e) Small hosp. resort town, Gulf Coast. $450, mtce. (f) New gen'l hosp. 125 beds, coll. town, So. $425-500. (g) Small gen'l hosp. coastal town, Fla. $450, mtce. RN10-2 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ASSISTANT DIRECTOR: School of practical nursing, degree in nursing required. Administrative experience preferred. 2 classes of 30 students per year. Duties include teaching nursing arts. 300 bed general hospital. Position open now. Apply Director, School of Practical Nursing, Columbus City Hospital, Columbus, Ga.

ASS'T DIRECTORS OF NURSES: (a) To work with dir. who will retire in about 9 mos. Assume some nurs. arts teach. until relieved when she assumes entire dept. $4200 and mtce to $4800 as Dir. MW. 160 beds. (b) 160 bed gen'l hosp., class of 70 students, needs ass't to Ed. dir. Full chg. very soon. Some adm. duties at once. $4200 and house or apt, as desired. MW. (c) Small class 30 stuents. 86 bed gen'l hosp. Ass't dir. of nurses, great student responsibility. Sal. open, mtce. Nr. lg. "U" med. center. (d) Ass't dir. qual to head OR service. At least B.S. deg. with 2 yrs. OR supr., exp. Coll fac. rank, Prof. of Nursing. Good organ. ability essential. 900 beds Med. coll. hosp. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

CLINICAL INSTRUCTOR: (Medical-Surgical Ward), 260 bed general hospital. School nationally accredited. Degree required, experience desirable. 40 hr. wk. Good personnel policies. Salary commensurate with preparation and qualification of applicant. Apply Director School of Nursing, Evangelical Deaconess Hospital, St. Louis 19, Mo.

CLINICAL INSTRUCTOR: For obstetric department of 65 beds in 225 bed hospital, 130 students in the school of nursing. Assume full responsibility for classroom and ward teaching in obstetrics. 40 hr. week, 4 weeks paid vacation, 7 paid holidays, sick leave accumulative to 30 days. Salary open. Apply Tacoma General Hospital School of Nursing, 314 South K St., Tacoma, Wash.

DIRECTORS OF NURSES: (a) Vol. gen. hosp. lge. size. Island of U.S. dependency,

considered tropical. Climate mild. Req's M.S. Degree. (b) East Coast resort twn, 283 bed gen'l hosp., sch. of 30 students. Need immed. BS Deg. nec. $6000 and mtce. (c) New 140 bed hosp. open Dec. 1, MW, invited to asst. in plans for future. Sal. open, pref. good exp. in lieu of deg. if nec. (d) Immed. need for 200 bed hosp. New Eng. coll twn. full acc'd hosp. Exp. pref. Will accept new grad. with deg. & initiative. (e) $6000, plus apt. Nurs. sch. 125, 17 RN's on staff of OPD, hosp. and clinic comb. Med. staff closed to 30 full time phys. Chief of staff is med. dir. Central Penn. twn. Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

DIRECTORS OF NURSES: (a) Vol. gen'l hosp. 410 beds, 170 students. Depts. well staffed. Univ. city, MW. (b) Fairly lge. gen'l hosp., interesting city outside US. Fine school. (c) Chief unit. univ. group, E. (d) Nursing service only. gen'l hosp. 175 beds, coll. town, Calif. (e) Nursing service, new hosp., 125 beds, coll. town, So. (f) Eminently successful group, 26 men, E. (g) Ass't dir. lge. teaching hosp., So. RN10-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

EDUCATIONAL DIRECTOR & NURSING ARTS INSTRUCTOR: 240 bed non-profit hospital, beautiful location and new nurses home. Open salary, full maintenance if desired, 40 hr. week, 4 weeks vacation and 14 days sick leave per yr. Degree required. Apply Director of Nurses, St. Joseph's Hospital, Reading, Pa.

FACULTY POSTS: (a) Nurs. arts instr. for sch. nurs. Aff'l "U" med. school, 250 students, 4-5 instr. in dept. Pre-clinic classes 85 in fall, about 35 spring. May direct own schedule, asst. in orientation prog. M.A. pref. Will accept B.S. with exp. in field. $4500. (b) Nurs. arts, instr. 260 bed Wis. hosp. 50 class enroll., 85 min. Chgo. (c) Sc. instr. lge full acc'd hosp. & sch. nurs. Lge. "U" and coll. twn, all benefits. Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

FACULTY POSTS: (a) Ed. dir., 160 students, attrac. city, outside US. (b) Ed. dir., new hosp., chief teaching unit univ. med. school. W. (c) Instructors in OR, OB, Ped., univ. hosp. Pac. Coast. (d) Ed. dir. children's hosp. outside US. (e) Public health & nursing arts instructors, near San Francisco. (f) Ass't nursing arts & med-surg. instructors. Collegiate school. Coll town, MW. $4200-$5000. RN10-4 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

CLINIC, COLLEGE, COURIER, INDUSTRIAL, OFFICE: (a) Clinic. Resort & univ. city, SW. (b) Courier. Transcontinental. (c) Indus. P.M. shift, attrac. oppor. Chicago. (d) Office, by board surgeon, near San Francisco. (e) Indus. nurse consultant. Leading insurance co. Some travel. (f) Student health nurse, univ. dept. W. (g) School. Chicago suburb. (h) School. Calif. $4000. RN10-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY NURSES: For 85 bed hospital. 40 hr. wk. Salary $247.50 per mo. Sick leave, hospitalization and Railroad Retirement benefits. Paid vacations. Apply to Director of Nurses, Denver and Rio Grande Western Hospital, Salida, Colo.

GENERAL DUTY NURSES: $265 days, $275 PM and nights, $10 increase after 1st year for 3 years. 40 hr. wk., paid vacation, sick leave and holidays. Hillside Hospital, 115 Alameda, Klamath Falls, Ore.

GENERAL DUTY NURSE: Registered. For 84 bed hospital, 40 hr. week, 3 weeks vacation, liberal sick leave. $270 per mo. plus $10 if on call. Time and one-half for overtime. Periodic merit increases, modern community, atomic energy project. Not Civil Service. Must be a citizen. Write Nursing Department, Los Alamos Medical Center, Los Alamos, N.M.

GENERAL DUTY NURSES: For medical, surgical and maternity services. New 200 bed hospital, good personnel policies, 44 hr. week, including 7 holidays, hospitalization, Social Security. Apply Director of Nursing, Chambersburg Hospital, Chambersburg, Pa.

GENERAL DUTY NURSES: 75 bed general hospital in Southern California. 40 hr., 5 day week. Prevailing salaries paid. Full maintenance available. Apply Director of Nurses, Redlands Community Hospital, Redlands, Calif.

[Turn the page]

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You can help sensitive, overweight youngsters lose weight by telling them about 'MELOZETS.'

A most important value of 'MELOZETS' it that they are a "drugless" help to any reducing regimen.

'MELOZETS' look and taste like graham crackers. Each wafer contains 1.5 Gm. of methylcellulose and supplies about 30 calories. 'MELOZETS' give a sense af satisfying fullness—blunt the appetite.

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GENERAL DUTY NURSES: For beautiful crippled children's hospital located in heart of historic west. Salary starts at $250 per month with complete maintenance, 15 days vacation, 15 days sick leave, 5 day work week. Climate is warm and dry. Hospital has indoor and outdoor pools available to personnel. Contact Director of Nurses, Carrie Tingley Hospital for Crippled Children, Truth or Consequences, N.M.

GENERAL DUTY NURSES: For 114 bed general hospital. Beginning gross salary $242 plus meals and uniform allowance. $10 evening and night bonus. 3-11 and 11-7 positions available. Apply Paul O. Huth, M.D., Supt., St. Francis Hospital, Cambridge, Ohio.

GENERAL DUTY AND OPERATING ROOM NURSES: For 345 bed maternity hospital 30 minutes from midtown Manhattan. Salary $2300. Excellent maintenance in addition to salary, 40 hr. week, 12 holidays and 14 days illness allowed annually. Vacation 14 to 28 days according to position and length of service. County pension plan. Opportunity for promotion and professional growth. Apply Director of Nurses, Margaret Hague Maternity Hospital, 88 Clifton Place, Jersey City, N.J.

GENERAL DUTY STAFF NURSES: For 165 bed hospital in residential suburb of Chicago. 40 hr. duty after 9/1/53. Cash salary $215 for day duty, $225 for evening duty and $230 for night duty. Full maintenance in addition to salary includes single room in new nurses' residence plus meals and laundry, which is equivalent to $335 per mo. Low rental apartments for married nurses, and $25 additional salary rate for nurses living in their own homes. $10 increase after 60 days and at regular intervals. Two to four weeks vacation, 6 holidays, sick time policy, free life insurance, Blue Cross hospitalization available. Leave of absence with full salary for post-graduate experience. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

GENERAL STAFF NURSES: For new 32 bed hospital opened 2 years. Liberal salary, excellent working conditions. Apply Administrator, Wells Municipal Hospital, Wells, Minn.

GENERAL STAFF NURSES: Medicine, surgery, obstetrics, nursery, operating room. Salary $215. $265 in 6 increments. 340 bed general hospital near 2 universities. Excellent personnel policy, 40 hr. week, overtime pay, 4 weeks vacation and 30 days sick leave after 1 year. Instaff education program, Social Security, Blue Cross, 8 paid holidays, pleasant working surroundings, advanced preparation encouraged. Apply Director of Nursing Service, Presbyterian Hospital, 27 S. 9th St., Newark, N.J.

GENERAL STAFF NURSES: 40 hour week Basic salary $220 with evening and night differential $10. Annual Salary increase, 2 weeks' vacation, 6 holidays, 14 days sick leave. New well-equipped 150-bed hospital near Sun Valley, Idaho. Apply to Director of Nursing, Magic Valley Memorial Hospital, Twin Falls, Idaho.

[Turn the page]

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GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary $280, $5 per month tenure increase for each 6 months of service to a maximum of $310. Social Security, sick leave, prepaid medical and hospital care, $10 additional for afternoon and night shift, $10 additional for delivery room, $20 additional for surgery. Up to 3 weeks vacation at end of 4 years. 7 paid holidays, 8 hr. day, 40 hr. week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GRADUATE NURSES: General duty for college infirmary (35 beds) in Hanover, New Hampshire. Starting salary $205, increases at intervals to $230. 40 hr. week, 10 months employment from September 1 to July 1 including 3 weeks vacation. Additional advantages in progressive and interesting community offering recreational and cultural opportunities. Write to Dartmouth College Health Service, Hanover, N.H.

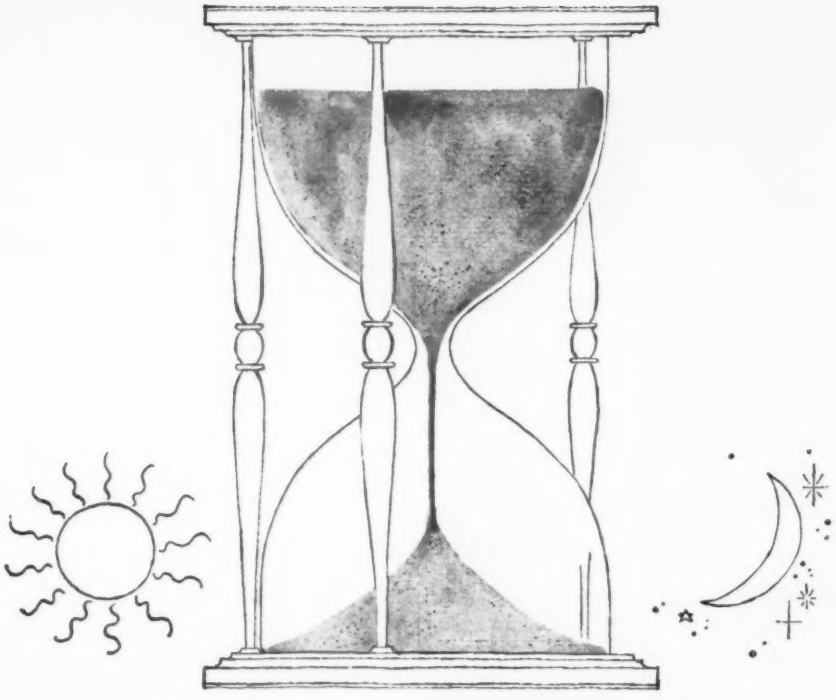
GRADUATE NURSES: 70 bed general hospital, general duty. $215 a mo., $10 extra for eves., nights and relief. Scrub nurses $225, $2.50 per call case. 6 mos. increases for 18 mos., merit thereafter. Full maintenance available. 24 days paid vacation the 1st year, 32 days thereafter. One day per mo. sick leave, cumulative to 45 days. 44 hr. week. Apply Director of Nursing, Mahaska Hospital, Oskaloosa, Iowa.

GRADUATE NURSES: Public Health Training Program open to graduate nurses 20 to 40 years, $3889 to $3971 per year. Trainees take academic work at University while gaining paid experience in field. Other openings for trained public health nurses, 22 to 45 years, $3971 to $4350 per year. 40 hr. week, liberal paid vacations, sick leave, pension system, Civil Service status, educational leaves. Apply Detroit Civil Service Commission, 735 Randolph St., Detroit 26, Mich.

GRADUATE NURSES: No experience necessary. Start at $295, increase after 6 mos. Work for State of California which pioneered 40 hr. week for nurses. Wide choice of attractive positions in special schools, correctional institutions, veterans home, and mental hospitals. Excellent promotional opportunities for nurses who specialize in psychiatric work in California's mental hospitals. Write today for new bulletins. State Personnel Board, 1015 L St., Sacramento, Calif.

GRADUATE NURSES: $3200 per year. May be increased before long. 42-44 hrs. per wk. May work additional hrs. with overtime pay. 20 days vacation, 20 days sick leave, 12 holidays. Civil Service status. Living accommodations may be procured. Hourly nurses $1.35 per hr. Dinner furnished, uniforms, laundry. Apply Director of Nursing, Newark City Hospital, 116 Fairmount Ave., Newark 7, N.J.

GRADUATE REGISTERED NURSES: 50 bed modern Poliomyelitis Respiratory Center needs general duty staff nurses for rotating



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SHIFTS. Starting salary $300 per mo. Medical school and college affiliations. Experience not required. Reply to Mary E. Stevens, R.N., Administrative Supervisor, Southwestern Poliomyelitis Respiratory Center, 1801 Buffalo Drive, Houston, Tex.

HEAD NURSES: (3) Delivery room. Rotating shifts, salary $220, $275 in six increments, 340 bed general hospital, near two universities, excellent personnel policy, 40 hr. wk., overtime pay, 4 wks vacation and 30 days sick leave after 1 year. Instaff education program, Social Security, Blue Cross, 8 paid holidays, pleasant working surroundings, advanced preparation encouraged. Apply Director of Nursing Service, Presbyterian Hospital, 27 So. 9th St., Newark 7, N.J.

MALE NURSES: (a) Dir. of nurses, small priv. psy. hosp. $5000-$6000, E. Degree req. (b) Psy. instructor, degree req. Lge. hosp., univ. city, MW. RN10-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

NURSE ANESTHETIST: For approved 160 bed pediatric hospital. Annual vacation and sick leave, retirement benefits. Apply Administrator, Milwaukee Children's Hospital, 721 North 17th St., Milwaukee 3, Wis.

NURSE ANESTHETIST: Starting salary $450 per month. 90 bed hospital, on call every other week end. Contact Administrator, Harrison Memorial Hospital, Bremerton, Wash.

NURSE ANESTHETIST: Approved hospital near Detroit. $450 per month. Overtime after 40 hours per week. Living quarters available. Wyandotte General Hospital, Wyandotte, Mich.

NURSE ANESTHETIST: 48 bed Municipal Hospital near Cleveland, Ohio. Good working conditions, maintenance if desired. State Pension Plan available. Apply, Miss Eleanore Cline, Bedford Municipal Hospital, Bedford, Ohio.

NURSE ANESTHETISTS: $375 per mo. for 44 hr. week, 8 hr. rotating shifts. Increased pay for overtime work in lieu of call. Contact Mr. Wonnacott, Administrator, L.D.S. Hospital, Salt Lake City, Utah. Telephone 9-8741 collect.

NURSE ANESTHETISTS: Two, 201 bed general hospital, pleasant working conditions. 40 hr. week, no split shifts. Salary $360-$415. Apply Dr. Robert Johnson, Herrick Memorial Hospital, 2001 Dwight Way, Berkeley 4, Calif.

NURSES: O.R. Supervisor, O.B. Supervisor, General Duty Nurses. Salary open. Blue Cross & Blue Shield, uniforms laundered, sick leave, holidays and vacation pay. 44 hr. week. Warrensburg Medical Center, Inc., Warrensburg, Mo.

NURSES: Registered, for staff positions. Liberal personnel policies. 40 hr. week. Salary $2912 to $3328. Regular increments. Day nursery for children of nurses. Fully approved. College affiliation. Near New York

and accredited universities. Saint Barnabas Hospital, 685 High St., Newark, N.J.

NURSES: General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSES: Staff and operating room. 5 days, 40 hr. week, initial salary $275. Additional for evening and O.R. calls. Maintenance if desired. Uniforms laundered. Write or call Supt. of Nurses, Yuma General Hospital, Yuma, Ariz.

NURSES: General Hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES-STAFF: For 140 bed general hospital. Starting salary $235-$250. Congenial working conditions, liberal personnel policies. 8 paid holidays, sick leave and vacations. 40 hr. wk. School of Nursing. Attractive Nurses' Home on premises. Located 5 minutes from downtown Newark, 40 minutes from Manhattan. Apply Director of Nurses, Clara Maass Memorial Hospital, 16-12th Ave., Newark, N.J.

NURSING ARTS & CLINICAL INSTRUCTORS: Degree and experience preferred. Salary depending upon preparation and experience. Small classes admitted annually. Clinical Supervisor for Med-Surg. depts. Apply Director of Nurses, Mercy Hospital, Benton Harbor, Mich.

OBSTETRIC SUPERVISOR: For 32 adult beds and 32 bassinets in a new wing of a 193 bed hospital. Teaching and administrative responsibilities. Liberal personnel policies including two increases per year for three years. Starting salary dependent upon preparation and experience ranging from $268.28 to $300. For further details apply to Director of Nurses, Mercy Hospital, Benton Harbor, Mich.

OPERATING ROOM NURSE: For 225 bed Southern California General Hospital. 40 hr. wk. plus on-call duty, salary range $255-$285. Paid vacation, sick leave. Housing available at $10 month. Apply Personnel Director, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

OPERATING ROOM NURSES: Starting salary $235, annual increase. 40-hour week, paid overtime. 2 weeks' vacation, 14 days sick leave. Six holidays. New 150 bed hospital near Sun Valley. Apply Director of Nursing, Magic Valley Memorial Hospital, Twin Falls, Idaho.

OPERATING ROOM NURSES: For 200 bed hospital. New and modern surgery. Good working conditions with 44 hr. work week. Apply Director of Nurses, Chambersburg Hospital, Chambersburg, Pa.

PEDIATRIC OR SUPERVISOR, GENERAL DUTY NURSES & SUTURE NURSES: 100 bed Pediatric Hospital—Medical, Surgical, Premature Nursery and Operating Room. 40

hr. week. liberal personnel policies. Living quarters available. Apply Director of Nursing, Babies' Hospital—Coit Memorial, 15-19 Roseville Ave., Newark, N.J.

PSYCHIATRIC NURSES: Supervisory and Staff positions open in private psychiatric and fully accredited hospital near Baltimore, Md. Staff nurses begin at $230 a month with periodic increases. Openings also at higher levels. Night duty differential, 4 weeks vacation and 7 holidays with pay, maintenance available at minimal cost. For further details write to Director of Nurses, The Sheppard and Enoch Pratt Hospital, Towson 4, Md.

PUBLIC HEALTH: (a) Four staff., 2 supervisors, county dept. So. Calif. (b) Head. gen'l prog., univ city, So. $5000-$6000. RN10-7 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

PUBLIC HEALTH: (a) RN with public health exp. to act as home visitation nurse, rural area, to ass't with public health ed. prog. also. $4000, up, Calif. (b) Complete charge dept. new position for MW hosp. to 250 beds. All modern, organization ability helpful, deg. pref. Must have exp. (c) Nursing consultant, supr. staff P.H. nurses in 7 counties, give related consult., service to all organized agencies, active dept. NW mountain area near nat'l pk. $4320 plus $9 a day per diem, plus state car or allow for own if desired. (d) RN or a deg. from recg. coll. Must have car. Assume position health educator for county TB ass'n, well organized and recognized group, full co-op, civic groups and indust, promote chest X-ray. Woodward Medical Bureau, 185 N. Wabash, Chicago 1, Ill.

PUBLIC HEALTH NURSES: Vacancies in New York City Department of Health. Immediate appointment on provisional basis. Generalized service includes maternal and child care, school health and communicable disease control. Starting salary $2930. 37 hr. week, liberal vacation and sick time allowances, pension rights, in-service training. Applicants (except New York State Veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth St., New York 13, N.Y.

REGISTERED NURSE ANESTHETIST: Starting salary $365. Automatic increases. 40 hr. week, no obstetrics. Liberal vacation and personnel policy. Sutter Hospital, Sacramento, Calif.

REGISTERED NURSE: For small general hospital. Liberal salary and complete maintenance with single room in modern residence. Rotate Shifts. Apply to Superintendent, Mary Chiles Hospital, Mt. Sterling, Ky.

REGISTERED NURSE: For general duty who can relieve lab technician every other week end. Willing to pay $300 per month for the right person. Location 30 bed modern hospital in beautiful Blue Mountain region of Eastern Oregon on main hiway Boise to Portland. Write air mail to Fred Waller, Administrator, Prairie City, Oregon.

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REGISTERED NURSES: All services, salaries $250, extras—evening or night, $20, operating room $30. 40 hr. week, Social Security and Retirement Insurance, all-graduate staff, 140 bed general approved hospital. Beautiful new nurses residence. City over 61,000, many cultural and education advantages. Apply Director of Nurses, Fort Hamilton Hospital, Hamilton, Ohio.

REGISTERED NURSES: If you are seeking a position in a 200 bed general hospital that offers metropolitan living 30 minutes from Detroit, excellent working conditions, liberal personnel policies with retirement plan and prepaid hospitalization, salary $279.07 with progressive increases, differential for evening and nights, write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

REGISTERED NURSES: Staff positions in all services for registered nurses at newly constructed 150 bed general hospital. Ideal geographical location 100 miles south of San Francisco on the Monterey Peninsula. Beginning basic salary $275. 40 hr. week. 2 weeks vacation. Blue Cross Hospitalization benefits carried by Hospital at no cost to employee. Apply Director, Nursing Service, Salinas Valley Memorial Hospital, 450 E. Romie Lane, Salinas, Calif.

REGISTERED NURSES: For staff nursing in General 160 bed hospital. Attractive personnel policies. Write Director of Nurses, Englewood Hospital, 6001 S. Green St., Chicago 21, Ill.

REGISTERED NURSES: Salary scale $227 to $260 per mo. Beginning salary based on length and recency of experience. Increases every 6 mos. Increases beyond the maximum on basis of merit. 2 weeks illness allowance, 3 weeks vacation. Rochester, N.Y., is noted for its beauty and for its recreational, cultural and educational opportunties: Broadway plays, concerts, advance nursing courses at the University. The Hospital is within 10 minutes of major shopping centers, theaters, and the University. Finger Lakes area within short driving distance. Address inquiries to Director of Nursing, The Rochester General Hospital, Rochester 8, N.Y.

REGISTERED NURSES: 27 bed general hospital. Starting salary $250, $275, 6 mos.; $300, 18 mos. Complete maintenance including laundry, meals and room in comfortable nurses' residence at no extra cost. Two weeks paid vacation. Retirement plan and other benefits. Liberal personnel policies. Apply Lincoln County Hospital, Caliente, Nev.

REGISTERED NURSES: Modern 43 bed hospital, general duty and operating room work. Good salaries with full mantenance. Pleasant climate and living conditions. Apply Isabella N. Williams, Administrator, Suwannee County Hospital, Live Oak, Fla.

REGISTERED NURSES: In progressive 250 bed hospital approved by the American College of Surgeons. Located in beautiful and exciting western city with ideal climate. 5½ day week (41 hrs.), starting salary $3180 per year, increases of $100 per year every 6 months up to 3 years, $10 extra for afternoon and night shifts and operating room, 6 paid holidays, 2 weeks vacation after 1 year, 1 day sick leave for each month of employment accumulative to 15 days, hospital insurance paid by hospital after 3 months employment, free laundry of uniforms. Nursery available for employees' children from 7 AM to 11 PM at the charge of $1 per child per day. Write Superintendent of Nurses, Washoe Medical Center, Reno, Nev.

NURSES: Registered, for positions in modern 115 bed community hospital in Greater Washington (D.C.) area. 40 hr. week, bonus for evening and night duty. Maintenance if desired. Apply Director of Nurses, Suburban Hospital, Bethesda, Md.

REGISTERED PROFESSIONAL NURSES: For general staff duty, for all shifts, 40 hr. wk., beginning salary $220 per mo. with a bonus of $20 for evening duty and $10 for night duty. Liberal personnel policies, Social Security. Apply Director of Nurses, Christ Hospital, Jersey City, N.J.

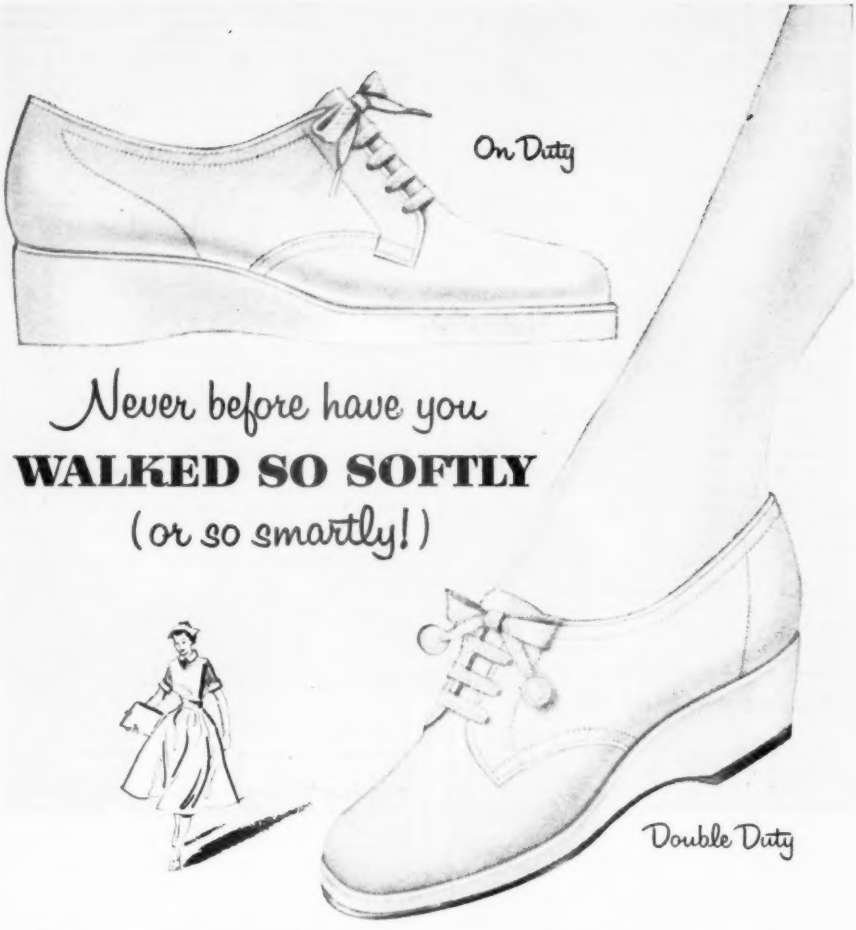
STAFF NURSES: Registered or eligible for registration in New York State. Starting salary $250 a month. Increase of $120 a year for two years. A bonus of $10 per month is given for operating room duty and night duty, $20 for 3-11 shift. Insurance, Social Security, 7 holidays, 4 weeks vacation after one year, 40 hr. week, laundry, sick time, living accommodations available at $22.50 for a double room, $30 for a single room, meals available at 33 1/3¢ per meal. Apply to Superintendent of Nurses, 218 Second Ave., New York, N.Y.

STAFF NURSES: Male or female, 105 bed fully approved by American College of Surgeons, Physical Medicine and Rehabilitation Hospital, predominately children, all convalescent cases. Begin $220 monthly, regular increases to $250 with complete maintenance included. Will pay $.06 mile transportation to accepted applicants. Air-conditioned hospital and quarters, liberal vacations, sick leave, Social Security, well located in relation to Austin, San Antonio and Gulf Coast. Delightful warm and dry winters. Contact Director of Nursing, Gonzales Warm Springs Foundation, Gonzales, Tex.

STAFF NURSES: Large psychiatric hospital with affiliate educational program. 5½ day week, straight hours, mostly day work. 12 holidays annually, paid vacation and sick leave benefits. Starting salary $262 per mo. Apply Director of Nurses, 5400 Arsenal St., St. Louis 9, Mo.

STAFF NURSES: Wide clinical experience. 40 hr. week, starting salary $280 a month. For further details please write to Department of Nursing, University Hospital, Ann Arbor, Mich.

STAFF NURSES: For new 200 bed approved general hospital in residential suburb of Cleveland. Private rooms available in new residence on scenic site at shore of Lake Erie. New "square" hospital contains every



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SURGERY NURSES: Assistant Head Nurses, $250 per mo. for 40 hr. wk., $272 for 44 hr. wk. Write Superintendent, Doernbecher Memorial Hospital for Children Unit of University of Oregon Medical School, Portland, Ore.

SURGICAL NURSE: For California schools and state hospitals. Must have or eligible for California license and have one year's surgical experience in approved hospital. $310-$358 month. Write State Personnel Board, 1015 L St., Sacramento 14, Calif.

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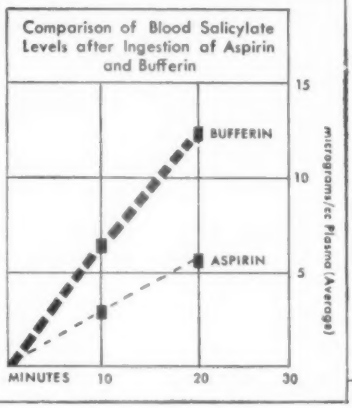

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1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950

2. Gastric Tolerance for Aspirin and Buffered Aspirin. Ind. Med. 20:480, Oct. 1951

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